GUIDE TO EXIBITS.

E. Prosecutor's Opening Address

F. Receipt for Japanese Latrine Buckets

G. Copy of admission and discharge book from Sep 27 - 42, to June 26 -43 at Sham-Shui-Po Camp.

H. Copy of admission and discharge book June 26 - 43 to August 21 - 45.

J. Monthly returns of sick POW in Hospital at North Point Camp book

K. Admission and discharge/North Point Camp

L. List of Drugs

M. Ration Scale of the Japanese Imperial Army

N. Red Cross Issue

O. Secret Forms

P. Receipt for Drugs by Col. Crawford

Q. Summary of deaths of Canadian POW's

R. Nominal roll of all Canadian personal sent to Japan

S. Admission and discharge book Bowen Rd. Military Hospital 8/12/41 - 8/4/42.

T. Translation diptheria

U. Japanese Original —

V. Colonel Kerin Affidavit

W. Reid's Affidavit (Major)

X. Capt. Reid's Affidavit

Y. Maj. Grey's "

Z. Maj.Gen. MaltbyMC (Affidavit)

A.1 Letter by Maj.Gen Maltby MC

B.1 Lt.Col. Price's Affidavit

C.1 Maj Atkinson's Affidavit

D.1 Lt.McCarthy's "

E.1 Cpl. Porter's "

F.1 Pte. Hankel's "

G.1 Pte. Hankel's "

H.1 Maj. Kerr's "

J.1 Maj. Kerr's "

K.1 Examination of Sviatoslav N. Potouloff

L.1 Capt. Strahan's Affidavit

M.1 Letter by Maj. Eshton Rose

B. J. A. G.
24/4/47
WAR CRIMES LEGAL SECTION

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N.1 Certificate by Maj. Ashton Rose re no anty diptheria anty toxin

O.1 Surgeon Lt. Jackson's Affidavit

P.1 Lt.Col. Shackleton's "

Q.1 Summary by Capt. Wellwood of the medical history of Canadian who were in Hong Kong and Japan

R.1 Further statement by Capt. Wellwood

S.1 Lt.Col. Robertson's Affidavit

T.1 Examination of Capt. Bard

U.1 Statement by Lt.Col. Bowie

V.1 Capt. Evans' Affidavit

W.1 Examination of Saito Sunkichi

X.1 Capt. Green's Affidavit

Y.1 - ditto -

Z.1 Cpl. Hurley's Affidavit

A.2 True extracts from the Affidavit of Rfm.Pihfer

B.2 Lt.Col. Holmes' Affidavit

C.2 Brig. Holmes' Affidavit

D.2 - ditto -

E.2 Summary of examination of S.F. Newton

F.2 " " " " H. Green

G.2 Rfm. Tibbetts' Affidavit

H.2 Sgt. Kerr's "

J.2 " Ballingall's "

K.2 Pte. Dukelow's "

L.2 Summary of examination of Capt. Barnett

M.2 Capt. Barnett's Affidavit

N.2 Maj. MacCaulay's Affidavit

O.2 Letter by Van Waarderberg R.N.N.

P.2 Letter by Lt.Commander Solway

Q.2 Lt. Huidekoper's Affidavit

R.2 Summary of examination of Tsutada Hitsuo

S.2 " " " " Harada Jutaro

T.2 Case Sheets

U.2 Pte. Hanel's Affidavit

V.2 " Hallquist's "

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W.2 Pte. Harding's Affidavit
X.2 L/Cpl. Shayler's "
Y.2 Lt.Campbell's "
Z.2 Pte. Berzenski's "
A.3 Lt.Bark's "
B.3 S/Sgt. McNaughton's Affidavit
C.3 CSM Logan's "
D.3 WO Kirouac's "
E.3 Rfm. Sweet's "
F.3 Sgt. Harlow's "
G.3 Rfm. Archibald's "
H.3 Cpl. Murray's "
Q.3 Pte. Baxter's "
K.3 Sgt. Routledge's "
L.3 Cpl. Meagher's "
M.3 Pte. Robertson's "
N.3 Sgt. Rodrigues' "
O.3 Pte. Baraskiwich's "
K.3 Examination of PO Harringtol's Affidavit
P.3 " " Sgt. Plumbel's "
R.3 " " L/Cpl Hills'
S.3 Statement of Tanaka Hitoshi
T.3 - ditto -
U.3 - ditto -
V.3 - ditto -
W.3 Statement of Col. Tokunaga Isao
X.3 - ditto -
Y.3 Statement of Capt. Saito Shunkichi
Z.3 " " Sadayoshi Nakonishi
A.4 S " " Tokunaga Isao
B.4 - ditto -
C4 Statement of R.C. Zindal
D.4 L/Cpl. Tyler's Affidavit
E.4 Capt. Royal's "
F.4 Pte. Woodhead's "

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G.4 Statement by Miss. LOO AH DIN

H.4 Photograph of King's Park and POW HQ.

J.4 Japanese original

K.4 Lists of deaths kept by Japanese and typed by Tse Dickuan

L.4 Stocks records of Jardine Matheson's given by H.F.Hopkins

M.4 True extracts fromthe file of new ASIATIC Chemical works

N.4 Receipt of salary and the allowances for August 1945 (in Japanese)

O.4 Receipt of salary and the allowances for August 1945 (in English)

P.4 List of graves and locations

Q.4 Summary of examination of A.W. Rance

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S.4 " " " " " " "

T.4 Summary of examination of LAU KAM

U.4 Extracts from the diary of Mr. Joseph Tausz

V.4 Prisoners of war regulation

W.4 Details extracts from the Prisoners of war treatment

X.4 Extracts from the prisoners of war labour regulations

Y.4 Administratative regulations for the prisoner of war

Z.4 Extracts from P.42 recollection of various regulations concerning POW's.

A.5 Treatment of POW patients

B.5 Expenditure and treatment plus medical supplies for POW's

C.5 Report of POW's short (BOR's)

D.5 Diagram of Sham-Shui-Po Camp drawn by Col. Tokunaga

E.5 Extracts from the ledgers and list of drugs and dressing recovered at re-occupation

F.5 Drawing of the Hong Kong POW's Camp HQ. drawn by Lt.Tabaka

G.5 Letter by Maj. Boxer

H.5 Copy of the China Mail dated 7th December 1946

J.5 Extracts from the Army Internal Service Regulations

K.5 Japanese deaths certificate (in English)

L.5 " " " " "

M.5 Closing Address for the Defence

N.5 Closing Address for the Prosecution

O.5 Discharge sheet of Capt. Busfield from 28 IGH.

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U.5 Letter from Maj. J. Saith Hong Kong VDC.

P.5 Particular of Accused's (Col.Tokunaga Isao)
Q.5 - ditto - (Capt. Saito Shunkichi)
R.5 - ditto - (Lt. Tanaka Hitoshi)
S.5 - ditto - (INT:TSUTADA Itsuo)
T.5 - ditto - (Sgt. Harada Jotaro)
U.5 Letter from Maj. J. Saith Hong Kong VDC.

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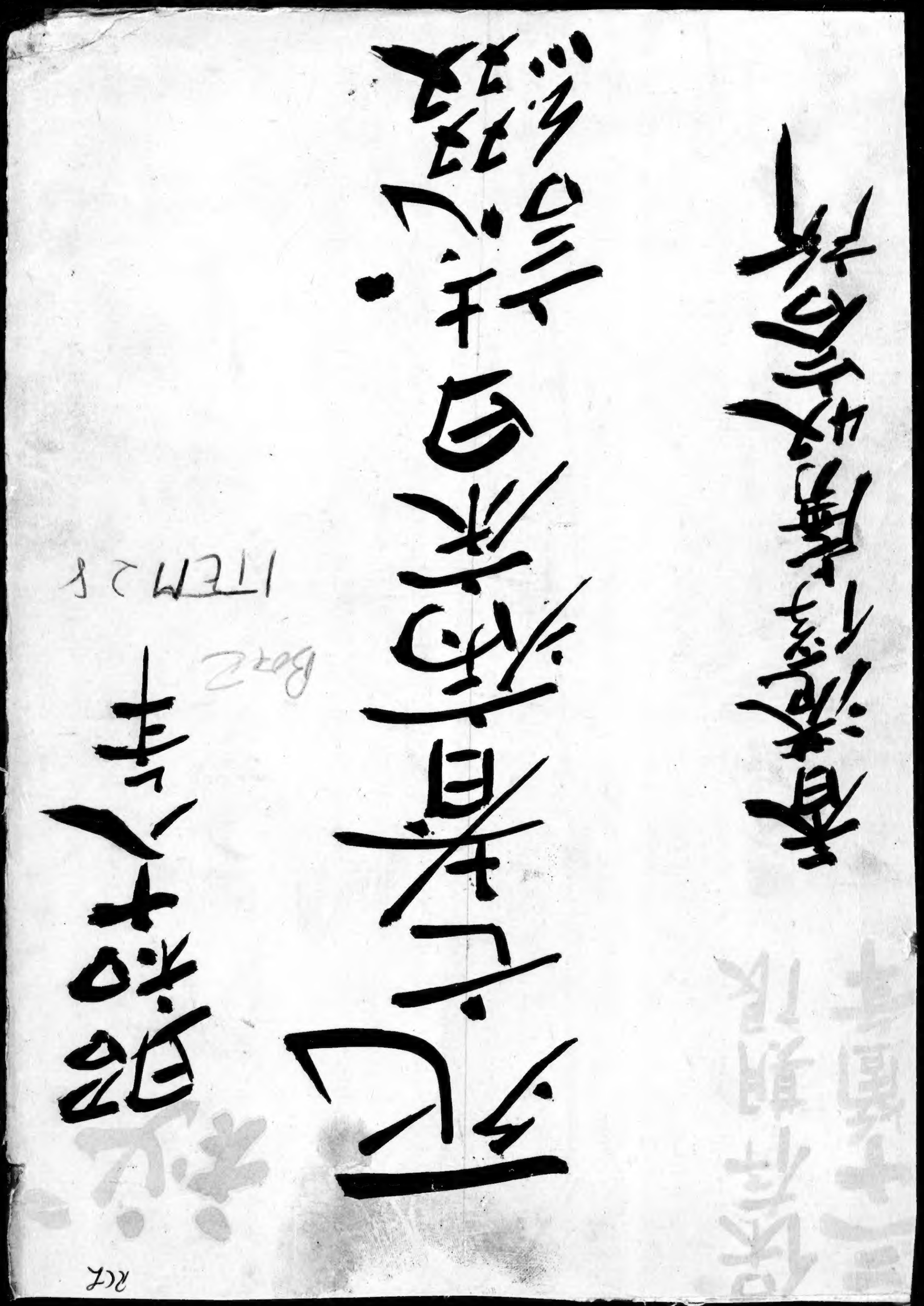

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Boston
Pouring 3

Flamingo Benjie Flying Cowgirl Atomic Jam
2 2 3 3+ 2

ADMISSION No. 1207. NAME of DOCTOR. Major J.D. Fraser, RAMC.

UNIT. R.R.Canada. NATIONALITY. Canadian. RANK. Rifleman NAME. LEGACY J.F.

NAME of DISEASE. Pellagra. DATE of ADMISSION 12.2.1943. DISCHARGE 20.2.1943.

DATE.	COURSE of DISEASE & TREATMENT.	REMARK.
	History from Shamshuipo Camp :-	
8.2.43.	Hot bath required. Trunk and limbs covered with papular eruption. seborhoeic in type - some circular scabbed patches on the back.	
10.2.43.	Mercurochrome on spots. Now clear.	
11.2.43.	Eyes :- Can't see features at 3 ft. Eyes water. R. mild conjunctivitis. Lotio Acid. Boric b.i.d. P.M. complains of not being able to see at all this evening. Mentally very slow. Nicotinic Acid. 2 300 mgms by mouth.	
12.2.43.	Mental condition very torpid. Says eyes verytroublesome-sore. But can see a little better. Legs, weak, spastic. Knee Jerks and ankle jerks exaggerated. P.R. ?? Ankle clonus both sides. Belly reflexes absent. Arms, spastic. Reflexes increased both sides. co-ordination tests not possible owing to lack of co-operation. ----------oOo-------- On admission patient mentally confused and unable to give a history. However, it was assumed from his statements and actions that he may have tightness of the chest, painful hot feet and numbness of face. General Examination :- Well covered with subcutaneous fat. Skin has many pustules over body, no oedema. Central Nervous System :- Pupillary reactions normal. Corneal reflexes present. Attempt to record vision impossible. View of fundus difficult. No apparent facial palsy. Legs and arms not unduly spastic. Deep reflexes exaggerated. Plantar response doubtful? Abdominal reflexes not ellicited. Cardio-Valvular System :- No appreciable increase of cardiac fulness. Sounds fine and good tone. Respiratory System :- Emphysematous type of chest. Precussion note hyper-resonant. No adventitial. Alimentary System :- Tongue: Red, smooth. Throat: Clear. Abdomen: Nil. No splenic enlargement. No tenderness in kidney angle. Normal Diet. Extras. Thiamine Chloride. 10 mgms. daily. Apellagrin. 20 mgms. b.i.d.	
13.2.43.	Poor sleep. Blood Slide : Negative. Eyes sticking together in the morning. Lotio Acid Boric. Gt.Zinc.Sulph. ½% t.i.d.	
14.2.43.	Mentally confused. Vision R. ?? 3/60 L. ?? 3/60. General condition I.S.Q.	
15.2.43.	Speaking in a whisper. Blood slide : Negative. In the evening became distressed and general condition deteriorated.	
16.2.43.	During the night vomited but slightly better this morning. Apellagrin. 100 mgms. by mouth. Awaiting sterilization of fresh supply. Quinine treatment started.	
17.2.43.	Bowels not moving. Enema given - retained. Chest - clear. Cardiac sounds poorer in tone. Urine :- 1022 Alkaline. No albumen sugar. Microscopic amorphous phosphate only. Still vomiting - bile stained.-	
18.2.43.	Tongue dry. Blood slide negative. No spleen. Still mentally confused. Rectal Saline with Glucose.	
19.2.43.	Incontinence of faeces. Saline stopped. Has stopped vomiting. Total :- W.B.C. 6,400 per cem. Differential Polymorphonuclears. 62% Lymphocytes. 38% ?? Splenic enlargement. Has been sweating profusely. Very much weaker.	

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DATE.	COURSE of DISEASE & TREATMENT.	REMARK

Rifleman. Legacy. J.F. R.R.Canada.

192.43. (Cont.). In Semi coma. Apellagrin 20 mgms. by intramuscular injection. Intravenous Quinine, 9 grs.
In evening general condition poorer. Rectal saline with Glucose. Cheyne Stokes breathing. B.P. 140/100 Legs and arms spastic.

20.2.43. Widal : Agglutination in B Typhosus H. 1/250 B Para A. 1/50 B Para B. 1/50 Nil in B Typhosus O.
Wiel Felix : no agglutination in B Proteus. OxK : OxL : OX 19.
Blood culture.:
General condition much poorer. Respirations increased. Chest moist. Cardiac sounds difficult to hear. More deeply in coma.
Later in the day condition deteriorated.
Patient died at 5.15 p.m.

POST MORTEM EXAMINATION :-

Peridardium : Normal.
Heart: Chambers. Valves. Muscle. Normal.
Lungs: Airless. No lesion noted.
Liver and Kidneys: Both appear within normal limits.
Spleen : Weight. 7½ ounces. No lesion.
Brain. No increased intra-cranial pressure. Meninges healthy. No macroscopic lesion noted in the brain.

Comment :

The Post Mortem examination revealed no gross lesion. The clinical examination produced a picture of dementia, increased reflexes, red, raw tongue, tightness of the chest, numbness and spacticity of legs and arms, suggestive of Pellagra.

Some observers describe a similar picture in cases of Pellagra ~~and~~ Typhus. Is this case one of the group?
Quinine Therapy was given as a precautionary measure although no evidence of malaria was present.

J. Brown

Major R.A.M.C.

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ADMISSION No. 1069 NAME of DOCTOR Major G. F. Harrison R. A. M. C.

UNIT R. R. C. NATIONALITY Canadian RANK ~~Rifleman~~ NAME Chicoine, G.

NAME of DISEASE. 1. Pulmonary Tuberculosis 2. Pellagra DATE of ADMISSION 26-11-42 DISCHARGE

DATE.	COURSE of DISEASE & TREATMENT	REMARK
26-11-42	Admitted complaining of anorexia and vomiting for ten days. Also diarrhoea since first attack of dysentery in September. Rash on legs and knees. Blurred Vision. Shooting pains in ankles and feet for one month. Patient's Past History: Dysentery January & September, 1942 History Present Illness: Dysentery started all his present troubles. Says it never really cleared up. At the best, bowels open 5 times per day and at the worst 12 times. No mention of a cough or any chest trouble. On Examination: Pale and emaciated body. Tongue--clean. Throat--clean. Heart sounds normal. Abdomen--nil abnormal palpable. Central Nervous System--Ankle reflexes exagerrated; Knee jerks absent. Lungs--crepitations present at right apex. Skin: There is a typical pellagrous rash (old) behind, and on the inner side of each knee. It is symmetrical and has pigmented borders. Backs of the hands have dark pigmented patches skin being rough. Treatment: Thiamin Chloride 10 mgms per day. Four times the normal ration of yeast. Iron tonic. Bismuth salicylate 1 oz. up to 6 doses. All available extras including milk.	
27-11-42	Appears very ill. Bowels opened three times last night.	
28-11-42	Not sleeping well. Still has diarrhoea. Complains of some pain in the right chest on breathing. On Examination: Crepitations at the right, upper zone of the lung as before.	
3-12-42	Appears slightly better. N.B.: Skin is very rough, indeed.	
8-12-42	Has started a cough. X-Ray Screening of chest shows: The appearance is typical of Pulmonary Tuberculosis. There is a cavity present in the right lung and a shadow in the left lung.	
9-12-42	Sputum: No Tubercle Bacilli found.	
12-12-42	Still complaing of pains in the legs and knees. It is very difficult to get any sputum from him as he swallows it. The left eye has a small milky plaque thereon.	
15-12-42	Still some diarrhoea. Tongue is smooth.	
17-12-42	Pains in fingers and hands. Hands felt cold.	

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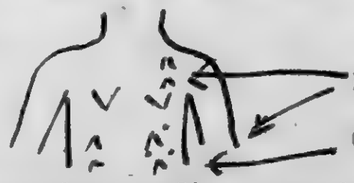
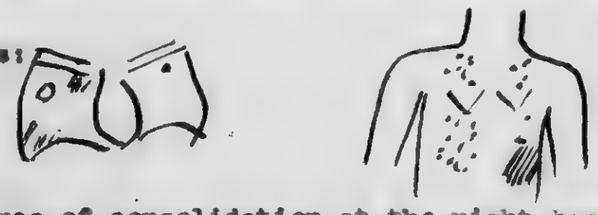
DATE.	COURSE of DISEASE & TREATMENT.	REMARK
17-12-42 (Cont.)	On Examination: Lungs-- Crepitations more marked now right mid-scapular region. Still has very little sputum.	
21-12-42	Sputum: No Tubercle Bacilli found.	
25-12-42	Miserable and depressed.	
26-12-42	Tongue still very red and shiny. Blood Pressure 130/110.	
	Lungs: 	
28-12-42	X-Ray Screening confirms previous impression. Is running slight evening temperature but still very little cough and no sputum.	
29-12-42	Sputum: No Tubercle Bacilli found.	
31-12-42	Feels weak. Bowels opened four times last night. Felt faint.	
4-1-43	Left eye is inflamed and has a small ulcer on cornea, for which he is receiving atropine drops and eye irrigations.	
	Treatment: Nicotinic Acid 150 mgms orally per day.	
6-1-43	Now complains of pain in the right chest on coughing.	
	On Examination: The right lung has crepitations and rhonchi over a wider area. Some also present in left lung.	
8-1-43	Blood Pressure: 115/90. Sputum: No Tubercle Bacilli found.	
16-1-43	Stop Nicotinic Acid by mouth. Has had 1.95 G. Lungs: Coarse crepitations presentright base; also over lungs generally.	
18-1-43	X-Ray Screening shows: 	
20-1-43	Lungs: There is an area of consolidation at the right base. Coarse crepitations are present all over both lungs.	
	Treatment: Trianon 4 Grams; also innalations t.d.s., in order to obtain sputum for examination.	
21-1-43	Rather delirious last night. Treatment: Trianon 3 Grams.	
22-1-43	Ulcer, left eye, still unhealed. Treatment: Trianon 3 Grams.	
25-1-43	Stop Trianon. Change to Thiamin Chloride 40 mgms. every other day.	
26-1-43	Urine: No albumen present.	
28-1-43	Nicotinic Acid 20 mgms per day intramuscularly.	
29-1-43	Poor appetite. Sleeps badly. Looks very ill. Tongue still smooth.	
1-2-43	No pain in feet. Pulse rate is increasing. Blood Pressure 90/40.	
2-2-43	Sputum: TUBERCLE BACILLI PRESENT. GAFFKY No. 4.	
3-2-42	Sputum: Tubercle Bacilli present. Gaffky No. 4.	

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DATE.	COURSE of DISEASE & TREATMENT.	REMARK
3-2-42 Cont.	Red Blood Cells -- 3,360,000. White Blood Cells 15,600. Haemoglobin -- 80%. Color Index -- 1.09. Polymorphs -- 84%. Lymphocytes -- 16%.	
5-2-43	Was incontinent of urine last night.	
7-2-43	Was incontinent of urine and faeces last night. Mind is wandering. Lungs: Coarse crepitations in profusion over both sides of chest. Heart sounds are of poor quality.	
8-2-43	Condition as before. Wandering in his mind.	
9-2-43	Slept intermittently. Still very confused. Mid-day, patient suddenly became unconscious, with twitching movements of the arms and legs. Bit his tongue. Heart sounds very weak.	
5:30 P.M.	Patient died.	

Treatment: Received a total of 360 mgms of Thiamin Chloride. Nicotinic Acid--1.95 G orally--.220 G intramuscularly--a total of 2.170 G. Also four times normal yeast ration. Iron Tonic. All available extras.

Report on the
Post Mortem Examination of the body of the late Rifleman Chicoine

Thin, emaciated body. Well-defined rash (pellagrous) on inside of knees. The pericardial sac had increased fluid.

Heart: Muscle and valves normal.

Lungs: Both lungs had widespread tubercular infiltration, which, in the right lung, was specially marked in the lower lobe; and in the left lung, was more marked in the upper lobe. The upper lobes of both lungs contained cavities about 1½" in diameter.

Spleen: Very small. Weight -- 2½ oz.

Liver: Normal.

Conclusion: It is evident from the X-Ray appearances that he had had Pulmonary Tuberculosis for many months before admission to Hospital. The lesion was comparatively small on first admission but there was subsequent, rapid peribronchial spread and dissemination to both lungs. The rash was typical of Pellagra. The Nicotinic acid appeared to do good.

(G. F. Harrison)
Major ----- R. A. M. C.
Medical Specialist.

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E1008

Admission No. 1069 Name of Doctor. Major G. F. Harrison R. A. M. C.

Unit. R. R. C. Nationality. Canadian Rank. Rifleman Name. Chicoine, G.

Name of Disease :- Date of Admission 26-11-42 Discharge

Date. 26.10.42. COURSE OF DISEASE AND TREATMENT. REMARKS.

AGE. 20 BEGINNING OF SYMPTOMS. (DATE). SEPTEMBER 1942

SYMPTOMS. I. SKIN AND MUCOUS.

ERYTHEMA. VESICLE. BULLA. DESQUAMATION.

FACE.
NECK.
ARMS.
HANDS.
PERINEUM.
LEGS.
FEET.

and Buttocks & Flexures of Elbow

Old Pigmented (healed) patch on inside of Knee Knee.

FOLLICULITIS. 11!
BLEPHARITIS.
STOMATITIS.
XXX GLOSSITIS. Very marked. Red. Smooth Tongue.
GINGIVITIS.
PHARYNGITIS.

Thin, pale, Emaciated.
Tachycardia.

II. GASTRO-INTESTINAL.

DYSPHAGIA.
x DIARRHOEA. Since September — on & Off
SENSATION OF EPIGASTRIC CONSTRICTION.

III. NERVOUS.

HEADACHES.
INSOMNIA.
DELIRIUM.
MANIA.
TREMOR.
x PARAESTHESIA. Shooting pains in feet for one month.
DEEP REFLEXES. Ankle Reflexes Exaggerated. Knee jerks absent.
XY VISION. Blurred vision.
Arcus Corneae ulcer. (Left eye)

Emotional Changes + (Very Depressed)

IV. BLOOD AND BLOOD PRESSURE.

Hypotension.

BP = 130/100 26/12/42

V. TREATMENT.

Tonic. Thiamin chloride 360ms.
15th Course ~~starting~~ 4/1/43 to 16/1/43. Methionine Tabs = 1.95 Grams (150ms per day)
2nd Course Intramuscularly 20ms per day. from 29/1/43 to date = .220
TOTAL = 2.17 G

VI. CONCLUSION.

Pellagra Rash is typical.
Also Latent Pulmonary Tuberculosis from which he died

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No. 25

CASE NO		NAME OF DIAGNOSING DOCTOR	Major [illegible] M.C.		
UNIT	[illegible]	NATIONALITY	[illegible]	NAME AND RANK	DAVIS, John Jr [illegible] 21 years.
NAME OF DISEASE	1. Cerebral Concussion. 2. [illegible]	DATE ADMITTED	[illegible]	DATE DISCHARGED	Died 1.18 pm. 1.3.43.

DATE	TREATMENT	REMARKS
31.J.43.	Admitted to Convalescent [illegible] General Hospital. Discharge [illegible] Diphtheria (Secondary). Slight degree of Vincent's.	
1.2.43.	Condition improved considerably.	
3.2.43.	Now appears to be quite well.	
1.3.43.	Suddenly dropped dead in bed [illegible] at 1.18 p.m.	

Lewis Balcombe-Rose
(L.C. Ashton-Rose,
Lieut. R.A.M.C.)

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Rifleman: S. Boudreau.

DATE	COURSE of DISEASE & TREATMENT -	REMARK
23/9/42.	Transferred from Dysentery Ward to Medical Ward. Diagnosis: 1. Dysentery. 2. Intestinal Haemorrhage. 3. Broncho-Pneumonia. 4. Heart Failure. Is still incontinent of Urine & Faeces (No blood or mucus in Stools). Appetite fair. No Vomiting -- no pain. On Examination: Is very pale. Tongue & Throat are clean. Heart sounds are normal. Lungs - Some fine crepitations at bases. Blood Pressure 110/70. Capillary Resistance Test is negative. Treatment: Food -- All extras including milk. Thiamin Chloride 10 mgm every day.	
24/9/42	Says he feels "not too bad". Is still incontinent almost hourly. Treatment: Soludagenham 3.0 grams per day by mouth. Fluids.	
25/9/42.	Slept fairly well but his general comdition this morning was poor. Pulse has become very rapid. Is still incontinent. On Examination: Tongue moist;appears dazed;persistent moaning. Looks very thin & exhausted. Cyanosis & diffuse subcautaneous capillary haemorrhage in the skin of the sternum. Heart sounds are normal: lungs as before. Treatment: Change to suphathiazole 4.o grams per day. Nicotinic acid 150 mgms per day. 2:30.P.M. 20 ccs of 50% Glucose given intravenously.	
8:00.P.M.	Breathing became slow. Pulse almost imperceptible. Appeared to be in a dying condition. He has been incontinent all day & has vomited twice. Treatment: 20.ccs of 50% Glucose given intravenously, as well as 30 mgms Thiamin Chloride intravenously. 1.7.ccs.Coramine subcutaneously.	
10:15.P.M.	Patient cyanosed, & ina state of collapse.	
10:20.P.M.	Patient died.	

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Rifleman: S.Boudreau.

CASE NO.		NAME OF DIAGNOSING DOCTOR			
UNIT.		NATIONALITY		NAME AND RANK	
NAME OF DISEASE				DATE:- ADMITTED	DATE:- DISCHARGED
DATE	TREATMENT.				REMARKS.

RESULTS of the POST Mortem Examination on the body of the Late Rfn.S.Boudreau

Trachea - Clean

Lungs - Both lungs, especially the left, showed large numbers of well-marked broncho-pneumonic patches, which had the appearance of Tuberculosis. Several smears were taken from these patches. No tubercle bacilli were found. There were no predominating organisms.

Pericardium - No excess of fluid.

Heart - Weight - 9.ozs. There was a large premortem clot in the right ventricle. In other respects the Heart was normal.

Liver - Normal.

Pancreas - Very hard and gritty to the touch.

Kidneys - Normal.

Spleen - Small. Weight 4½ ozs.

Gut.- Descending Colon - About 14" were of a dark greyish-black color, almost necrotic, the tissue being very friable (evidence of old haemorrhage), no ulcers were seen. There was no other evidence of Dysentery at the time of death.

All Tissues - Were extremely pale (from the haemorrhage).

Conclusion- This Patient died from extreme Anaemia & Heart Failure, the result of Intestinal Haemorrhage. He was also suffering from Broncho - pneumonia, which may have been Tuberculosis, although no laboratory evidence of this is available.

Sgd: G. F. Harrison.
Major. R.A.M.C.

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CASE NO. [redacted]

No.	775		Name of Diagnosing Doctor		Major I. [illegible], R.A.M.C.
Unit	R.A.C.	Nationality	Canadian	Rank	Sgn. S. Boudreau
				Name	
Name of Disease	1. Dysentery 2. Intestinal Haemorrhage 3. Broncho-pneumonia 4. Heart Failure	Date Admitted	11.9.42.	Date Discharged	Died 25/9/42.

Date	Treatment	Remarks
Sept 11.	General Condition poor Frequent stools, blood & mucus. Beri-beri neuritis. Vit B.	Bed.
12	B.O. 11 in 16 hrs. Feed (1) Soln Dagenan.	
13	General condition poor. Pad. B.O.+++ Soln Dagenan Attack in night - poor rapid pulse Cold sweat ?Internal Haemorrhage	
14	B.O. 5 or 6 in night. Pulse 112.	
15	Vomited blood in night. ?Bleeding Plus. Soln dagenan Alkaline powder 2 hourly 2 hourly liquid feed	
16	Still Restless - thirsty. Pulse 108. Temp 100. Soln Dagenan.	
23.9.42	Transferred from Dysentery Ward to Medical Ward. Diagnosis: 1. Dysentery 2. Intestinal Haemorrhage 3. Broncho-Pneumonia 4. Heart Failure. Is still incontinent of Urine & Faeces (No blood or mucus in stools). Appetite fair. No vomiting - no pain. On Examination: Is very pale. Tongue & Throat are clean. Heart sounds are normal. Lungs - some fine crepitations at bases. Blood Pressure 110/70 Capillary Resistance Test is Negative. Treatment: Food -- all extras including milk. Thiamin Chloride 10 mgm every day.	
24.9.42	Says he feels "not too bad". Is still incontinent almost hourly. Treatment: Soludagenham 3.0 grms per day/mouth by. Fluids	
25.9.42	Slept fairly well but his general condition this morning was poor. Pulse has become very rapid. Is still incontinent. On examination: Tongue moist: appears dazed; persistent moaning. Looks very thin & exhausted. Cyanosis & diffuse subcutaneous, capillary haemorrhages in the skin of the sternum. Heart sounds are normal; lungs as before.	

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CASE NO. [redacted]

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	Continuation
				Name	Rfn. S. Boudreau
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
25.9.42.	Treatment: Change to sulphathiazole 4.0 grams per day. Nicotinic acid 150 mgms per day. 2:30 P.M. 20 ccs of 50% glucose given intravenously.	
8:00 P.M.	Breathing became slow. Pulse almost imperceptible. Appeared to be in a dying condition. He has been incontinent all day & has vomited twice.	
	Treatment: 20 ccs of 50% Glucose given intravenously, as well as 30 mgms Thiamin Chloride intravenously. 1.7 ccs Coramine subcutaneously.	
10:15 P.M.	Patient cyanosed, & in a state of collapse.	
10:20 P.M.	Patient died.	

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CASE NO. 27.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	Continuation
				Name	Rfn. S. Boudreau
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks

Results of the Post Mortem Examination on the body of the late Rfn. S. Boudreau.

Trachea - Clean.

Lungs - Both Lungs, especially the left, showed large numbers of well-marked broncho-pneumonia patches, which had the appearance of Tuberculosis. Several smears were taken from these patches. No tubercle bacilli were found. There were no predominating organisms.

Pericardium - No excess of fluid.

Heart - Weight - 9 ozs. There was a large premortem clot in the right ventricle. In other respects the Heart is normal.

Liver - Normal.

Pancreas - Very hard & gritty to the touch.

Kidneys - Normal.

Spleen - Small. Weight 4½ ozs.

Gut - Descending Colon - about 14" were of a dark, greyish-black color, almost necrotic, the tissue being very friable (evidence of the old haemorrhage), no ulcers were seen. There was no other evidence of Dysentery at the time of death.

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CASE NO.

No.			Name of Diagnosing Doctor		G.F. Hamilton R. A. M.C.
Unit	M. G.	Nationality	Canadian	Rank	Private
				Name	D. Hawkes
Name of Disease	1. Diphtheria 2. Diarrhoea & 3 Beri-Beri	Date Admitted	20.9.42.	Date Discharged	

Date	3. Heart Failure Treatment	Remarks
20.9.42 5:00 P.M.	Complained of sore throat for 7 days, diarrhoea for 4 months, eczema of scrotum for 2 months, pains in the chest, swelling of ankles for 3 months. Also had pains in the legs for 3 months with muscle cramps & tingling & numbness of feet and hands. On examination - Large thick white membrane on right tonsil. Both sides of neck much swollen with painful glandular enlargement. Some angular stomatitis & smooth tongue. Heart sounds appear normal. Knee & ankle reflexes present & equal. Plantar respones flexor.	Walking
11:30 P.M.	Appeared to be in no particular distress till 11:30 P.M.; when he called for an Orderly. When the Orderly reached his bedside, he was choking. The Orderly Medical Officer saw him and performed a rapid tracheotomy.	
11:50 P.M.	Patient died.	
Conclusion:	Although there was no time for a Lab Report to be received, on his throat swab, it is evident from the condition of his throat that he had Diphtheria. His history strongly suggests Beri-Beri. C.F. Hamilton, Major - R.A.M.C. Medical Specialist.	

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CASE NO. 538

No.	583		Name of Diagnosing Doctor		Major. G.F.Harrison R.A.M.C.
Unit	W. G.	Nationality	Canadian	Rank	Pte.
				Name	W. Harkness
Name of Disease	Diphtheria Septic Penis & Scrotum Toxic Nephritis Heart Failure	Date Admitted	11.9.42	Date Discharged	Death 21/9/42.

Date	Treatment	Remarks
11.9.42	Complained of lack of appetite, sore feet & sore mouth for about 3 months. Also, considerable loss of weight (42 lbs.). Had eczema of scrotum for 3 weeks. On admission: Scrotum swollen & ulcerated in patches. Mouth & throat, clean. Treatment: Sulphathiazole 1 gram 4 hourly. Lysol to scrotum. Thiamin Chloride 10 mg.	Stretcher
13.9.42	Complains of sore throat this afternoon. Has white membrane on left tonsil. Left gland (cervical) enlarged. Lab Report on Throat Swab - No K.L.B or Vincent's organisms seen. Transferred to Throat Ward.	
13.9.42	Says feels much better. Treatment: Gargles. Hot irrigations to throat.	
14.9.42	Throat much worse. Treatment: Mandle's Paint & hot irrigations.	
15.9.42	Lab Report on Throat Swab - No K.L.B or Vincent's organisms seen.	
16.9.42	Membrane on left tonsilar region has increased in size. Feels weak. Heart sounds are normal. Treatment: Continue hot irrigations. Stop Mandle's. Is on all extras. Sugar drinks.	
17.9.42	Throat condition as before. Penis very swollen. Treatment: Change to glycerine & ichthyol. (to Penis and scrotum)	
18.9.42	Membrane on tonsil very thick. Heart sounds are becoming weaker.	
19.9.42	Lab Report on Urine - Albumen present. Pus cells. Red blood Cells. Scanty casts. N.B. Is coughing up thick, purulent matter from the throat. Treatment: Sulphathiazole 5.0 grms. Hot Lysol irrigations. Has been having Thiamin Chloride 10 mgs. every day. Is on milk & all other extras as well as glucose drinks.	
20.9.42	Complained of difficulty in breathing during early part of last night. Treatment: Sulphathiazole 5.0 grms. Lead lotion to scrotal area.	
21.9.42	Feels very weak. General condition much worse. Respirations have become very rapid. Pulse rate very rapid & feeble. At about 8:00 A.M. became rather cyanosed. Blood Pressure 70/45. 8:20 A.M. Patient died.	

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CASE NO.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	Pte.
				Name	W. Harkness
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
	(Continuation)	
	CONCLUSION: Althought the Lab Reports were Negative, the Thick white membrane & the offensive smell, were typical of Diphtheria. It was evident from the examination of the Urine & from the Post Mortem examination that he also had Toxic-Nephritis. From the fact that he had sore feet & sore mouth & lack of appetite for 3 months, it is very probable that he was suffering from B Avitaminosis as well.	
	G.F. Harrison,	
	Major - R.A.M.C.	

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CASE NO. 588.

No.			Name of Diagnosing Doctor		Major G.F.Harrison R.A.M.C.
Unit	W.G.	Nationality	Canadian	Rank	Pte.
				Name	W. Harkness.
Name of Disease	Diphtheria Septic Penis & Scrotum Toxic Nephritis, Heart Failure	Date Admitted	11-9-42	Date Discharged	21-9-42

Date	Treatment	Remarks
11-9-42	Complained of lack of appetite, sore feet & sore mouth for about 3 months. Also, considerable loss of weight (42 lbs.). Had eczema of scrotum for 3 weeks. On admission: Scrotum swollen & ulcerated in patches. Mouth & throat, clean. Treatment: Sulphathiazole 1 gram 4 hourly. Eusol to scrotum. Thiamin Chloride 10 mg.	
12-9-42	Complains of sore throat this afternoon. Has white membrane on left tonsil. Left gland (cervical) enlarged. Lab Report on Throat Swab - No K.L.B. or Vincent's organisms seen. Transferred to Throat Ward.	
13-9-42	Says feels much better. Treatment; Cargles. Hot irrigations to throat.	
14-9-42	Throat much worse. Treatment: Mandle's Paint & hot irrigations.	
15-9-42	Lab Report on Throat Swab - No K.L.B. or Vincent's organisms seen.	
16-9-42	Membrane on left tonsilar region has increased in size. Feels weak. Heart sounds are normal. Treatment: Continue hot irrigations. Stop Mandle's. Is on all extras. Sugar drinks.	
17-9-42	Throat condition as before. Penis very swollen. Treatment: Change to glycerine & icthy.(to penis & Scrotum)	
18-9-42	Membrane on tonsil very thick. Heart sounds are becoming weaker.	
19-9-42	Lab Report on Urine - Albumen present. Pus cells Red blood Cells. Scanty Casts. N.B. Is coughing up thick purulent matter from the throat. Treatment: Sulphrathiazole 5.0 grams. Hot Eusol irrigations. Has been having Thiamin Chloride 10 mgs. every day. Is on milk & all other extrasas well as glucose drinks.	
20-9-42	Complained of difficulty in breathing during earl part of last night. Treatment: Sulphratiazole 5.0 grams Lead lotion to scrotal area.	
21-9-42	Feels very weak. General condition much worse. Respirations have become very rapid. Pulse rate very rapid & feeble. At about 8:00 A.M. became rather cyanosed. Blood Pressure 70/45. 8;20 A.M. Patient died. Conclusion: Although the Lab Reports were Negative, the thick white membrane & the offensive smell, were typical of Diphtheria. It was evident from the examination of the Urine & from the Post Mortem examination that he also had Toxic-Nephritis. From the fact that he had sore feet & sore mouth & lack of appetite for 3 months, it is very probable that he was suffering from B Avitaminosis as well.	

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CASE NO.

No.	443		Name of Diagnosing Doctor		Major, G.F.Harrison
Unit	W.Grenadiers	Nationality	Canadian	Rank	Pte.
				Name	D. H. Moore
Name of Disease	Diphtheria	Date Admitted	7.8.42	Date Discharged	

Date	Treatment	Remarks
7.8.42	Admitted with very sore throat, which came on 4 days before admission. On examination whitish membrane on right tonsil. Uvula deep red. Lab report on Swab - No Vincent's organisms. A diphtheroid organism present, some resembling K.L.B. Treatment: Diphtheria anti-toxin 38,000 units intramuscularly. Gargles.	Stretcher
10.8.42.	Throat seems better. Heart sounds normal. Urine contains no albumen.	
12.8.42.	Throat almost clean. Heart sounds normal. Treatment: Continue Gargles.	
14.8.42	Throat clean. Heart sounds normal.	
21.8.42	Has felt perfectly well & seems to have recovered except that he complains of some pain in the left side of the cheek.	
22.8.42	Left ear feels blocked up. Treatment: Hot water bottle to left ear.	
28.8.42	Still having trouble with left ear. Treatment: Sulphonamide 3.0 grams per day.	
1.9.42	Stop Sulphonamide. Temperature normal.	
5.9.42	Heart sounds are normal but pulse rate is rapid.	
11.9.42	Still feels deaf in left ear. No abnormality seen by auriscope.	
13.9.42	Onset of Colitis. Some blood & mucus in stools.	
14.9.42	Treatment: Sodium sulphate 1 oz. hourly for 6 doses. Has got palatal paresis. Nasal voice quite marked. (N.B. - Complication of diphtheria)	
15.9.42	Sodium sulphate 1 oz. 2 hourly for 3 doses.	
16.9.42	6 to 8 stools last night. Treatment: Start sulphapyridine 4 grams to-day. N.B.- Regurgitation of fluid through the nose, on swallowing, is quite marked. He experienced so much difficulty today in swallowing fluids, from this cause, that an	

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CASE NO.

No.	443		Name of Diagnosing Doctor		Major, G.F.Harrison
Unit	W.Grenadiers	Nationality	Canadian	Rank	Pte.
				Name	D.F. Moore.
Name of Disease	Diphtheria	Date Admitted	7.8.42.	Date Discharged	

Date	Treatment	Remarks
	(Continuation) oesophageal tube was passed & 1 pint of milk was given through the tube.	
17.9.42	Sleepless night. Very restless. Bowels opened about 7 times in spite of having had 3 oz. of Bismuth Salicylate (45 grains). Treatment: Sulphapyridine 3.0 grams. Bismuth Salicylate 1 oz. 6 times. Heart sounds normal but pulse rate is becoming very rapid.	
2.00 P.M.	Sudden difficulty in breathing. On examination: Skin cyanosed. Rapid, shallow inspirations. No evidence of any paralysis of the respiratory muscles, which are working well. Pule rate extremely rapid.	
2.30 p.m.	2 cc. Coramine subcutaneously & 2 cc Coramine intravenously. Also, continuous oxygen.	
9.15 pm.	Another attack of great respiratory distress. Oxygen again started. 40 mg. Thiamin Chloride given intravenously & oxygen for 15 minutes every hour ordered. Coramine 2 cc. 2 hourly.	
11.15 pm.	20 cc. of 50% glucose solution given intravenously. During the night, pulse rate became 160. He became semi-delirious with short, jerky respirations, cold extremities.	
18.9.42	at 3.50 A.M. the patient died. Conclusion: From the results of the Post Mortem Examination, which were chiefly Negative, it is to be concluded that he had bulbar paralysis, causing heart failure. The bulbar paralysis, being a late complication of the Diphtheria. G.F. Harrison, Major - R.A.M.C.	

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CASE NO.

No.	584		Name of Diagnosing Doctor		Major G.F. Harrison R.A.M.C.
Unit	R.A. of Canada	Nationality	Canadian	Rank	Rifleman
				Name	N.A. Coffin.
Name of Disease	1.Cardiac Beriberi 2.Nephritis 3.Heart Failure	Date Admitted	11.9.42	Date Discharged	

Date	Treatment	Remarks
11.9.42 at 6.00 P.M.	Complaining that he could not eat for the last 17 days. Was discharged from Camp Hospital 9.9.42, convalescent from Dysentery, but later became too weak to move & was transferred to this hospital at the hour stated. On admission - Patient semi-delirious. Had had pains in the feet on or off for the past 3 or 4 months. On Examination - Appeared to be in a dying condition. Skin cyanosed. Tongue extremely dry, red & glazed. Breath had ammoniacal smell. Throat covered with dry mucus. Heart rate extremely rapid & feeble. heart sounds tic-tac & distant. Lungs - an occasional crepitation, nothing else. No evidence of pneumonia. Placed on Dangerously Ill List. Treatment: 40 mg. Thiamin Chloride intravenously.	Stretcher.
12.9.42	Stated to have slept quite well. Pulse rate - 136. Appears much worse. Short, shallow respiration. Blood Pressure 70/40. Lab. Report on Urine -- Albumen ++, Deposit shows epithelium present ++. Tubular casts +. Red blood Cells & Puss Cells.	
11.30 A.M.	Treatment: 30 mg. Thiamin Chloride intravenously.	
2.00 P.M.	30 Mg. Thiamin Chloride intravenously.	
5.00 P.M.	Patient died suddenly.	

Conclusion: It is evident from the history & the postmortem examination that the patient had acute Cardiac Beri Beri, as well as a toxic-nephritis.

G.F. Harrison,
Major, R.A.M.C.
Medical Specialist.

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CASE NO.

No.	670		Name of Diagnosing Doctor	J. Duncan, Major
Unit	W.Grenadiers	Nationality	Canadian	Rank: Pte.
				Name: Loffat, J.A.
Name of Disease	Acute Colitis beri-beri	Date Admitted	29.8.42.	Date Discharged

Date	Treatment	Remarks
1942		
Aug.29.	6 days illness. Abdom.cramp. Blood & mucus for 5 days. Pale, weak, emaciated. Absent-knee & ankle jerk. Chond-	Stretcher Case. Blood - mucus in stool.
Aug.30	B.O. 10 in 9 hours.Mucus (1) Pot Brom. ā ƒ℥v (2) Sod. Sulph, ℥ℓ 4 hly (2) ℥ℓ 4 hly.	
31	B.O. 18.	
	10.30 pm. Coughing tonight. Rather collapsed. Pulse weak & lapsed. Stop salts	
	T.99 P.128 R.44 — (Coramine inj. (Bromly. ℥ℓ Repeat 4 hourly.	
Sept.1.	6.45 a.m. Very weak. Pulse worse. — Coramine Bromly.	
	9.45 a.m. Unconscious.	
	Slight improvement. Pulse still v.weak.	
	Pulse 140 Temp. 97.2 — Sulphathiazole 2 tab. Flucote freely + Glucon.	
	Chest R.Base — Coramine	
	9 p.m. Still unconscious, but drinks fluids.	
	Pule - imperceptible Respiration - 50. — ddying.	
Sept.2	310 a.m. Died.	

J. Duncan,
Major
R.A.M.C.

Post Mortem: Cause of death. Failure of beri-beri heart.

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CASE NO. 11

No.	663		Name of Diagnosing Doctor		Major DURRAN
Unit	R.A.M.C.	Nationality	Canadian	Rank	Rifleman
				Name	Antila, L.
Name of Disease	Acute Colitis	Date Admitted	29/8/42	Date Discharged	

Date	Treatment	Remarks
29.8.42	Admitted B.M.Hospital Acute Colitis for 3 weeks. Very Toxic and collapsed Hiccup for 3 days. Bowels - Faecal - Loose - mucus. Hiccup severe. M Morphia ƒ 1/3 Atropine ƒ 1/110 CO_2 inhalations. Controlled for over hour by CO_2. 9 p.m. Pentothat Sod. .25 gm. (Stopped Hiccup until 4.30 am.)	
30.8.42	4.30. a.m. CO_2 failed. Penthothat Sod. .25 gm.	
	5.30 a.m. Chloroform inhalation	
	6.00 a.m. Chloroform inhalation	
	10. a.m. Has been comatose all night. Still unconscious.	
	11. a.m. Intravenous ƒmm Saline 0ŦŦ	
	During day. Intravenous Continuous Drip Glucose 10 % in Saline 0ŦŦ	
	Did not regain consciousness.	
	Condition of heart deteriorated. Hiccup did not recur.	
	10.30 p.m. Death from heart failure.	
	Post mortem:	
	Acute toxic flabby heart.	
	Immediate cause of death. Toxic myocarditis.	
	J. Durran.	
	Major	
	H.K.V.D.C.	

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ADMISSION No. 465. NAME of DOCTOR: Major G.F. Harrison. R.A.M.C.

UNIT. R.C.C. Signals NATIONALITY. Canadian. RANK. Signalman. NAME. LITTLE. J.C.

NAME of DISEASE. Acute Colitis. Paralytic Ileus. Heart Failure. DATE of ADMISSION 4.6.1942. DISCHARGE 5.6.1942. (DIED).

DATE.	COURSE of DISEASE & TREATMENT	INITIALS.
4/6/42.	Patient Past History. Has been fit in Camp. History of Present Illness. Has been admitted to N. Point Camp Hospital with FEVER on 22/5/42. Diarrhoea Streaked with Blood & Mucus. B.O. 5 times Today. Treatment Mist Kaolin Zj 4hrly for 6 doses.	Shoulder.
5/6/42.	Is VERY TOXIC. Lower very ill. Pulse almost imperceptible. Badly dehydrated. Lips pale. BP 70/60 Stools Semi-solid mucus blood mixed. Abdomen Sounds not audible. Heart Enlarged for Cardiac CNS Extensors & R. Knee & Plantar flexors of R. ankle weak. R/A Reflexes absent: Some Conj tenderness.	
8.30 am.	Treatment:- 50 mg Thiamine Chloride intramuscularly. 1/100 gr Strychnine Sulphate. Rep 6thly 2hrly. x 4. Rectal Tube passed 6" Rectum. End of Bed. Left Lateral position. Catheter & Catheterised.	
	D. 1. List	
During Morning	Has had Small Fecal B.N.O. Did not pass urine. Less catheterised. No urine passed. Condition deteriorating.	
2 p.m.	Has vomited. & Again at 3.20 p.m.	
3.25 p.m.	Has died.	

Result of Post Mortem Examination

Heart Small. 3½ oz. Pericardial Sac in excess. Small Patches milky spots. Evidence of past Cholecystitis. Paralytic Ileus Stomach & Stomach & Jejunum distended. Lower 2/3rds of Gut deeply congested. Mucus Membrane in Colon. In places Black in colour. Ileum Pale. Conditions generally Appearance. Has died of Acute Colitis & Paralytic Ileus.

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Major RAMC

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死亡.

入院番号 Admission Number	77	診断軍医名 Name of Doctor	Major G.F. Thomerison. R.A.M.C.		
	R.C.A.S.C.	国籍 Nationality	Canadian	階級氏名 Rank & Name	Sgt: Carter, A.E.
	Bac: Bmi: Dysentery (Amoebic)	入院月日 Date of Admission	13.4.42	退院月日 Date of Discharge	Died 1 a.m. 22/4/42

Date	治療 Treatment		
13/4/42.	8.10pm. Thiamin Chloride (Vitbi) 30 mg intravenously.	Streptin	Extremely ill.
	Bismuth Subsalicylate ℥j — 3 hrly.		
14/4.	Thiamin Chloride 25 mg intravenously.		Fever.
	Bismuth Subsalicylate ℥j — 6 hrly.		
	Phenol & Opium Enema Nocte.		
15/4.	1/3 gr Emetine Hydrochloride.		
	Nocte Morphine gr 1/4		
	Luctic Chloride Hydrochl. gr 15		
	P.R. Bmi gr 15.		
16/4.	Thiamin Chloride 5 mg Subcut. Emetine gr 2/3.		V. Grave.
	Per Haustus. — Peppermint Aqua. — Vinegum. — Bismuth Soda. — Ipecacuanha & Co2. — Strychnine — Respirin — Mist Alba. — Luminal.	All fluids without success.	
17/4.	Fluids ad lib. Rep drugs per Haustus.	Emetine gr 2/3. Streptin & Opium Enema.	
18/4.	Thiamin Chloride (Vit B1) 10 mg Subcut. Morphine gr 1/3 Nocte.	Emetine gr ℈	
19/4.	Emetine gr ℈ 20/4 Emetine gr ℈		

21/4. Thiamin Chloride 5 mg Subcut Emetine gr ℈. 第一体限.

Died at 1 pm. 22/April

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Admission Number. 1390. Name of Doctor. Major G.F. Harrison. R.A.M.C.

Unit. Winnipeg Grenadiers. Nationality. Canadian. Rank. Private.
Name. Hamelin. F.F.
admission. 12.10.1943.
Diagnosis :- PULMONARY TUBERCULOSIS. Date of discharge. DIED. 10.12.1943.

	Course of Disease and Treatment.	Remarks.
Oct 12th.1943.	Admitted from Shamshuipo Camp complaining of a cough for three weeks also pain in the left chest after meals for four weeks. PAST HISTORY :- Dysentery 4 weeks ago. FAMILY HISTORY :- No History of Tuberculosis. HISTORY OF PRESENT ILLNESS :- Says that the cough produces a cupful of sputum every day. Four weeks ago he first had pain under the left clavicle which occurred one hour after meals, and sometimes on taking a deep breath. He also has numbness of both feet. Also has night sweats. ON EXAMINATION :- Mouth and tongue clean. Heart sounds are normal. LUNGS. Medium crepitations present over both lungs. ABDOMEN - Nil abnormal palpable.	
Oct 13th.	X-RAY SCREENING - Both sides show infiltration and cavities.	
	Laboratory Report on Sputum:- "TUBERCLE BACILLI PRESENT GAFFKY NO: 7"	
Oct 16th.	Cough is marked at night. Appetite is very poor. (Tr. Linctus Codeine for cough s.o.s. Is propped up in bed and is having all available extras including milk.	
Oct 18th.	BLOOD SEDIMENTATION RATE - 83 mm. in 1 hour. (WESTERGREN).	
Oct 19th.	Complains of pain the left chest on breathing. On examination - Friction fremitus is easily heard. (Tr. Apply strapping to chest. Laboratory reports ova of ascaris in stool. (Tr.Oil Chenopodium mms. XII).	
Oct 22nd.	Has passed two round worms.	
Oct 23rd.	Friction fremitus still very marked. Much pain. (Tr. Re-apply strapping	
Oct 26th.	Feels much better. On examination - breath sounds bronchial at right apex with consonating crepitations.	
Oct 28th.	Cough has increased. No pain now in chest. Friction fremitus has disappeared.	
Nov 2nd.	Right lung seems a bit clearer.	
Nov 7th.	Poor day. Pulse weaker. Sleeps badly. PLACED ON THE DANGEROUSLY ILL LIST.	
Nov 8th.	General deterioration of his condition. Rapid respirations. Pulse rate almost uncountable.	
Nov 10th.	On examination - Has extreme difficulty in breathing. (Yesterday was feeling quite well). Apex beat is palpable to the right of the mid sternal line. Left lung tympanitic. The physical signs suggest that he has an acute pneumothorax. (Tr. A needle was inserted into the left chest and the reading of the Pneumothorax Apparatus showed a positive pressure, confirming the diagnosis. 350 ccs of air were removed).	
Nov 11th.	Breathing much easier. Evening :- As respirations were again distressed a needle was inserted into the same place as yesterday and 100 ccs of clear fluid were removed. A needle inserted under the left clavicle obtained air. He now has a Hydro-Pneumothorax.	
Nov 12th.	?dextra sPlash sounds easily heard.	

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Course of Disease and Treatment.		Remarks.
Nov 17th.	Respirations again distressed.	(Tr. 2 pints of clear, greenish fluid were removed from the left pleural cavity).
Nov 23rd.	Further difficulty in breathing.	(Tr. 3 pints of clear fluid removed from the left pleural cavity).
Nov 28th.	Feeling very much better. Pulse rate slower. Fairly cheerful.	
Dec 6th.	Respiratory embarassment has again increased.	(Tr. 2 pints of clear fluid removed from the left pleural cavity).
Dec 8th.	Evening :- Breathing very distressed.	(Tr. 700 ccs of air removed from the left pleural cavity with much relief to the patient).
Dec 9th.	Appears more comfortable. Evening :- General deterioration in his condition. Respirations rather rapid. Pulse very feeble.	
Dec 10th.	Patient died at 6.50 a.m.	

RESULTS OF THE POST MORTEM ON THE BODY OF THE LATE PTE. F.F. HAMELIN. W.C.

On opening the chest the air and fluid was found in the left pleural cavity, (Amount of fluid very small). The left lung was collapsed. There was acute pleurisy on the left side. The right lung was firmly fixed to the chest wall. The lung was removed only with considerable difficulty.

LEFT LUNG :-

RIGHT LUNG :-

Pericardial fluid slightly increased. HEART - Normal. LIVER, KIDNEYS AND SPLEEN - All Normal.

SMALL INTESTINE showed many typical tuberculus ulcers. Mesenteric glands were much enlarged.

CONCLUSION :- He died from Pulmonary Tuberculosis which was widespread in both lungs. There was very little hope of his recovery at any time.

Major R.A.M.C.

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ADMISSION NUMBER. 1076. NAME OF DOCTOR :- Major G.F. Harrison, R.A.M.Corps.

UNIT. Winnipeg Grenadiers. NATIONALITY. British. Rank. Private.
Name. Tamson. A.J.

DIAGNOSIS :- Lymphadenoma. Date of - Admission. 18.12.1942. Discharge. 17.12.1943. (BY DEATH).

Date.	Course of Disease and Treatment.	Remarks.
1942. 18.12.	Admitted from Shamshuipo Camp Hospital. Complains of (1) Painful feet for three months. (2) Numbness of chest, arms and legs. (3) Blurred vision.	
	PATIENTS PAST HISTORY :- Dysentery April and May, 1942. Periodic diarrhoea since then. No other illnesses.	
	FAMILY HISTORY :- Mother - Kidney trouble.	
	HISTORY OF PRESENT ILLNESS :- Six months ago he had sores all over the body which took three months to heal. Soon after this he developed blurred vision and then his feet began to hurt him. Numbness then started after which he developed general weakness of the body.	
	ON EXAMINATION :- There are the remains of a corneal ulcer on the left eye. He has Angular Stomatitis. There are various pigmented spots on the body, the skin generally is very rough. There is a large mass of glands on the right side of the neck. Enlarged glands also present in right axilla and in both groins. Heart and Lungs appear normal. Nil abnormal palpable in belly. Central Nervous System :- Power. There is bilateral weakness of the dorsiflexors of both ankles. All reflexes, superficial and deep, are absent. Sensation. Absent vibration sense over legs, absent joint sense and sense of position in legs. (The appearance of the glands strongly suggests a diagnosis of Lymphadenoma). Tr. B.D. Thiamine Chloride daily.	
19.12.	W.B.C. 10,000. Differential. Polys. 69% Lymphos. 28% Monos 2% Transitionals. 1%. No abnormal cells.	
21.12.	Bowels open 10 times in the last two days. No blood or mucus. X-Ray chest (Screening) shows :- Tr. Mist. Sod. Sulph.	
	N.B. The voice is very hoarse, as if the trachea was being pressed upon.	
25.12.	Diarrhoea has stopped. Sleeps fairly well. Hands are numb. Emotional attack to-day. Blood Pressure : 130/90.	
5.1.43.	Weight. 138 lbs. Now says he has had cramps in legs for 1½ years and which are very painful. Tr. Calcium Lactate. 90 grs per day. Vision is improving slightly.	
14.1.	URINE - Nil abnormal. Cramps have gone.	
8.2.	Weight. 132 lbs. Much weakness of flexors and extensors of both ankles still. Central Nervous System - As before.	
11.2.	Skin still very rough. Eye-sight is improving. Weight. 135 lbs.	
22.2.	Is beginning to walk. Balance rather unsteady. Voice has improved greatly.	
1.3.	X-Ray chest shows same appearance.	
9.3.	More diarrhoea.	
24.3.	The mass of glands in the right axilla appeared larger.	
13.4.	X-Ray chest shows slight increase of mass, (presumably glands).	
26.4.	There is a slight degree of Rombergism.	
28.4.	Mass of glands in neck and right axilla is much larger. Eye Specialist's report on eyes :- V.A.R. 6/6. V.A.L. 6/6. D.-0.3 (R). D.-0.3 (L). Discs of good colour. Vessels normal. Macula some stippling of pigment.	
3.5.	W.B.C. 11,800. Differential. Polys. 72% Lymphos. 21% Eosins. 2% Transitionals. 1% Primitive Polys. 2%. No abnormal cells.	
9.5.	Muscle cramps again. Tr. Calcium Lactate. grs 60 per day.	
1.6.	Glands in right side of neck and in right axilla have much increased in size.	

TO SHEET NO. 2/.

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1.6.43. (Cont). Major J.W. Anderson, RAMC., excised a gland from the right side of the neck for microscopic examination.

11.6. Says for the last 10 days he has had pain over the right praecordium.
X-Ray (Screening) shows :-

5.7. Has been suffering from cramps in the belly. Wil abnormal found in stools.
Central Nervous System :- Vibration sense still absent below the hip. Temperature sense absent below the knees. Pin-prick absent below the knees. Light touch absent around the ankles.
Laboratory Report on section of gland removed from neck :- Cut surface pale and firm. Microscopic Examination :- Normal Lymph gland structure absent. Considerable apparent increase in Reticulum and Reticulo-Endothelil cells. Reduced number of Lymphocytes. Scattered Eosinophills. Fairly large number of Mononuclear cells and a few ? Multi-neucleated cells. This picture is consistent with that of Chronic Productive Tuberculosis but also with Hodgkin's Disease. The possibility of the latter disease is more likely.

22.7. Further diarrhoea. Tr. Bismuth. Salicyl. s.o.s.
26.7. Still has diarrhoea. Tr. Alsilin Weiss. 4 H.
31.7. The glands in both groins are much enlarged and tender.
12.8. Glands in neck appear larger.
14.9. Says he has had gross skin irritation for the last 6 months.
Calcium does not seem to have much effect on him.
X-Ray (Screening) of chest shows :-

1.10. Groin glands are very tender. Skin irritation is worse.
Tr. Try Ext.Thyroid Sic. grs 3 per day.

8.10. For the last seven days has had swelling of ankles and this had gradually spread upwards. Nil abnormal in urine. Pains in chest are developing. Cough is increasing.

12.10. Complains of difficulty in taking a breath.
On examination : Occasional rhonchus in the right chest. Breath sounds are harsh.

16.10. The whole body is covered with very itchy papules for which no drug appears to be of much use. He coughed a small account of blood stained sputum to-day.

22.10. Cough is becoming very marked. Tr. Linctus Heroin & Codein s.o.s.

29.10. Abdomen is now distended with fluid.

3.11. On examination : Coarse crepitations present in right upper chest, also whispering pectoroloquy. At right base there is diminished to absent vocal fremitus with diminished breath sounds. (Evidence of fluid).

8.11. The glands in the neck and in the right axilla seem to be much smaller than they used to be.

11.11. Says he nearly choked last night. His general condition is deteriorating. Face is becoming hollower. Tends to have sudden diarrhoea.

15.11. R.B.C. 2,900,000. Haemoglobin. 40 per cent.
W.B.C. 8,000. Differential. Metamyelocytes. 1%
Stab cells. 19%
Polys. 74%
Lymphs. 5%
Eosins. 1%

17.11. Patient slept till 2.30 a.m., and then became very noisy. A sedative was given. This morning it is evident that he is dying.
PATIENT DIED AT 8.15 a.m.

To sheet 3/.

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17.11.1943. RESULTS OF POST MORTEM EXAMINATION ON THE BODY OF THE LATE PTE. SAMSON. W.G.

HEART :- Pericardium thickened. Marked increase in pericardial fluid. The heart itself appeared normal.

LUNGS :- Light brown fluid, about 200 ccs., present in each pleural cavity. No adhesions.
LEFT LUNG - Basal congestion. White, firm area about 3 to 5 millimetres sub-pleural on lateral side of lower lobe. This extended into the lung tissue about 2 to 3 millimetres. Old healed T.B. lesion at apex.
RIGHT LUNG - Large triangular infiltration of mediastianal glands into lung substance involving the greater part of the upper lobe and a part of the middle. On section this firm white mass had invaded and completely replaced most of the upper lobe and the border was fringed with finger like processes extending into the apparently healthy lung tissue.
All mediastinal glands were enlarged, white and of firm consistency.

ABDOMEN :- Abdomen contained about 1,500 ccs of straw coloured fluid.

(a) Stomach and intestines apparently normal.

(b) Kidneys and adrenals apparently normal.

(c) Spleen - Normal shape but slightly larger than usual. Surface was covered with dark nodular growths about 1.5 cms. in diameter. On section the cut surface was hard, almost gritty and showed many round white areas of infiltration.

(d) Liver - The majority of the normal liver tissues of the left libe was replaced by yellowish white nodules of various sizes protruding from the surface. Right lobe was not so much involved. On section the nodules were shown to occupy most of the liver substance and were not discrete, small prolongations extending into the normal appearing tissues.

(e) Pancreas. - Firm white glands involved the head of the pancreas. They did not appear to have invaded the pancreatic tissue.

Mesenteric glands enlarged. Both groups of glands in inguinal region enlarged, firm, but not fixed.

The general appearance was that of Hodgkin's Disease, (lymphadenoma), with Lymphosarcomatous changes.

Hong Kong.
7.11.1943.

Major R.A.M.Corps.

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00036

CASE NO.

No.	588		Name of Diagnosing Doctor		Major G.F. Harrison R.A.M.C.
Unit	W. G.	Nationality	Canadian	Rank	Private
				Name	Harkness, W.
Name of Disease	Diphtheria Septic Penis & Scrotum Toxic Nephritis Heart Failure	Date Admitted	11.9.42	Date Discharged	Death 21/9/42.

Date	Treatment	Remarks
11.9.42	Complained of lack of appetite, sore feet & sore mouth for about 3 months. Also, considerable loss of weight (42 lbs). Had eczema of scrotum for 3 weeks. On admission: scrotum swollen & ulcerated in patches. Mouth & throat, clean. Treatment: Sulphathiazole 1 gram 4 hourly. Lysol to scrotum. Thiamin chloride 10 mg.	STRETCHER
12.9.42	Complains of sore throat this afternoon. Has white membrane on left tonsil. Left gland (cervical) enlarged. Lab. Report on Throat Swab - No K.L.B. or Vincent's organisms seen. Transferred to Throat Ward.	
13.9.42	Says feels much better. Treatment: Gargles. Hot irrigations to throat.	
14.9.42	Throat much worse. Treatment: Mandle's paint & hot irrigations.	
15.9.42	Lab. Report on Throat Swab - No K.L.B. or Vincent's organisms seen.	
16.9.42	Membrane on left tonsilar region has increased in size. Feels Weak. Heart sounds are normal. Treatment: Continue hot irrigations. Stop Mandle's. Is on all extras. Sugar drinks.	
17.9.42	Throat condition as before. Penis very swollen. Treatment: Change to glycerine & ichthyol (to Penis & scrotum)	
18.9.42	Membrane on tonsil very thick. Heart sounds are becoming weaker.	
19.9.42	Lab. Report on Urine - Albumen present. Pus cells. Red Blood Cells. Scanty casts. N.B. Is coughing up thick, purulent matter from the throat. Treatment: Sulphathiazole 5.0 grams. Hot Lysol irrigations. Has been having Thiamin Chloride 10 mgs. every day. Is on milk & all other extras as well as glucose drinks.	
20.9.42	Complained of difficulty in breathing during early part of last night. Treatment: Sulphathiazole 5.0 grams. Lead lotion to scrotal area.	

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CASE NO.:

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	Private
				Name	W. Harkness
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
21.9.42	Feels very weak. General condition much worse. Respirations have become very rapid. Pulse rate very rapid & feeble. At about 8:00 A.M. became rather cyanosed. Blood pressure 70/45.	
8:30 a.m.	Patient Died.	
Conclusion:	Although the Lab Reports were negative, the thick white membrane & the offensive smell, were typical of Diphtheria. It was evident from the examination of the Urine & from the Post Mortem examination that he also had Toxic-Nephritis. From the fact that he had sore feet & sore mouth & Lack of appetite for 3 months, it is very probable that he was suffering from B Avitaminosis as well.	

G. F. Harrison,

Major, R.A.M.C.

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CASE NO: 1

No.	783		Name of Diagnosing Doctor		Major G.F. Harrison. R.A.M.C.
Unit	W. G.	Nationality	Candian.	Rank	Pte.
				Name	PASTUCK. N.
Name of Disease	1.DIPHTHERIA. 2.INTERNAL HAEMORRHAGE 3.HEART FAILURE.	Date Admitted	12.9.42.	Date Discharged	DIED 26.9.42.

Date	Treatment	Remarks
12.9.42.	Diagnosis : 1. Diphtheria. 2. Internal Haemorrhage. 3. Heart Failure. Complain of :- Sore throat for 1 week. Patients past History :- Burning pains in the leg for 1 month. Sore mouth for 2 months. Dysentary in April, 1942, for 6 weeks. History of Present Illness :- Sore mouth & Sore Tongue fo 2 months. Sore throat for 1 week. Headache. His eyes smart, when he goes into the sun. On Examination :- There is a small, white membrane on the right tonsil. The neck glands on each side are rather enlarged. Tongue is smooth, Shiny & red. Heart sounds are strong & normal. Central Nervous Syster - Knee reflexes present & equal. Angle reflexes are both diminished. Vibration sense is normal in the legs. No calf tenderness. Treatment:- Hot irrigations to throat. Thiamin Choloride 10 mgms. Labaratory Report on Throat Swab :- No Klebs Loefflers Bacilli. Scanty Vincent's organisms present.	
13.9.42.	Feels "not too bad". General condition very much as before. N.B. - Has septic right index finger (? same infection as throat; i.e. cutaneous diphtheria.) Treatment : As before. Also, mag. sulphate dressing to right finger.	
14.9.42.	Membrane on right tonsil is much larger to-day. Heart sounds are normal. Treatment :- Mandle's paint, & hot irrigations.	
15.9.42.	Did not sleep well. Throat is painful. On examination :- The membrane has increaded in size & has spread to the uvala, which is much swollen. There is also some angular stomatitis. A bloody, purulent discharge comes from each nostril (he has had this for 2 days). Heart sounds are normal. Treatment:- Stop mandle's paint. Repeat hot irrigations, Anti-phlogistine to neck. Sulphathiazole 6.0 grams per day. Laboratory Report on Throat Swab :- No klebs loefflers Bacilli or Vincent's organisms found.	
16.9.42.	Throats seems better. Heart sounds are slow & strong. Treatment:- Is having 10 mgm Thiamin Chloride per day. Sulphathiazole 4.0 grams to day.	
17.9.42	No change. Laboratory Report on Urine. No Albumen present. Treatment:- As before. Sulphathiazole 3.0 grams to-day.	
18.9.42	Throat is still very sore. Heart rate is becoming more rapid. Treatment:- Sulphathiazole 3.9 grams to-day.	
19.9.42	No change. Stop Sulphathiazole.	

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(Sheet No. 2.)

CASE NO. 1.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	Private.
				Name	N. PASTUCK.
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
21.9.42.	There has been much bleeding from the mouth & nose for the last two nights. On Examination :- Mouth & nose are full of blood clots. Knee jerks are both exaggerated. Treatment:- Mouth washes only.	
22.9.42	There is a large, raw area around the anus. (There is no diarrhoea). Treatment:- Add. Multi-vit capsules 2 per day. Ointment to anus. On Examination:- Hearts sounds are normal. Blood Pressure 110/80. Capillary Resistance Test - Negative.	
23.9.42	Does not feel so well. Headache all yesterday. Has had much bleeding from the nose, which is still bleeding slightly. There is evidence of haemorrhage in the skin of the left eyelid. Pulse rate strong & slow. Treatment:- Ice ro nose.	
24.9.42.	Nose bleeding continues ar intervals, but he says he feels all right.	
25.9.42.	Nose bleeding all last night. Vomiting of some greenish fluid. Treatment:- Continue gentle mouth washes Add ascorbic acid tablets two per day.	
26.9.42.	The haemorrhage over the left eye is darker & larger than it was. The nose & throat still tend to bleed. Vomited at 8.30 A.M. a large amount of greenish fluid. Right neck is now rather swollen. Nose & mouth are full of clotted blood. Treatment :- Calcium gluconate intravenously - slowly given.	
11.30 A. M.	General condition critical. Is pulseless & pale. There are haemorrhages under the skin of the right arm. The index finger of the right hand is dark & it is evident that there has been bleeding into the skin, around the sore. Heart sounds are much more rapid than they were this morning.	
11.45. A. M.	Patient gave a series of gasping respirations & his heart stopped. The patient died.	

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CASE NO: 4

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	Private.
				Name	N. PASTUCK.
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks

RESULTS OF THE POST MORTEM EXAMINATION ON THE BODY OF THE LATE PRIVATE N. PASTUCK.

There were haemorrhages in the skin of the left eyelid and of the right arm on its external aspect.

Trachea:- No membrane present. Just above the vocal chords there was a mass of blood-stained necrotic tissue, which part of the wall of the trachea (it was not detachable. & therefore, presumably was not old blood clot.)

Lungs: The anterior surface of both lungs showed well-marked sub-pleural haemorrhages. On sectioning the lungs both were widely studded with large haemorrhages, which were more marked in the right than in the left lung.

Pericardium: No excess of fluid.

Heart: Right side rather dilated. Muscle rather flabby. Valves normal.

Liver: Normal.

Gall Bladder: Enlarged, hard & red.

Spleen: Slightly enlarged. Firm. Weight 5½ozs.

Kidney: Normal.

Conclusion: It is evident from the history of pains in the legs, sore mouth & sore tongue & from the appearance of the tongue, which was smooth & shiny & deep red, & also from the angular stomatitis, that this Patient was suffering from Avitaminosis B. He died from the effect of Diphtheria; that is to say, Heart Failure & the Haemorrhages, which were the result of the intense toxaemia.

G. F. Harrison.
Major - R. A. M. C.
Medical Specialist.

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00042

Date W/O	Name of Corpsman	Duties	G.C. GRAY, Capt-in, R.C.A.M.C.
Unit	Royal 31st Regt of Canada.	Mathematics	Geography and Physics
Name of disease.	Dysentery.	Date Admitted	27.9.42
		Date Discharged	28.9.42.

DATE	TREATMENT	REMARKS
27.9.42	Fluids only.	Cold and liquor in stool.
28.9.42	Fluids only.	Patient extremely toxic and dehydrated. Gradually became worse and ceased to breathe at P.M.

(sgd) G.G. GRAY,
Capt., R.C.A.M.C.

CASE NO.

No.			Name of Diagnosing Doctor		Major.G.F.Harrison.
Unit	W. G.	Nationality	Canadian	Rank	Private
				Name	HAWKES. D.
Name of Disease	1. Diphtheria. 2. Diarrhoea & Beri-Beri. 3. Heart Failure.	Date Admitted	20/9/42	Date ~~Discharged~~ Death.	20/9/42.

Date	Treatment	Remarks
20/9/42. 5.00.PM.	Complained of sore throat for 7 days, diarrhoea for 4 months, eczema of scrotum 2 months, pains in the chest, swelling of ankles for 3 months. Also had pains in the leg for 3 months. with muscle cramps & tingling & numbness of feet & hands. On Examination -- Large thick white membrance on Right tonsil. Both sides of neck swollen with painful glandular enlargement. Some angular stomatitis & smooth tongue. Heart sounds appear normal. Knee & ankle reflexes present & equal. Plantar responses flexor.	Walking.
11.30.PM.	Appeared to be in no particular distress till 11.30.P.M., when he called for an Orderly. When the Orderly reached his bedside, he was choking. The Orderly Medical Officer saw him and performed a rapid tracheotomy.	
11.50.PM.	Patient died. Conclusion: Although there was no time for a Lab Report to be received, on his throat swab, it is evident from the condition of his throat that he had Diphtheria. His history strongly suggests Beri-Beri. G.F. Harrison. Major -- R.A.M.C. Medical Specialist.	

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CASE NO.		NAME OF DIAGNOSING DOCTOR.	DOCTOR.	ajor. G.F. Harrison. R.A.M.C.			
UNIT	M.E.F.	NATIONALITY.	Canadian.	NAME AND RANK.	Private. D. Hawkes.		
NAME of DISEASE	1. Diphtheria. 2. Diarrhoea & Beri-Beri 3. Heart Failure.			DATE:- ADMITTED	20.9.42.	DATE.- DISCHARGED	Died:- 11.50 P.M. 20.9.42.

DATE.	TREATMENT.	REMARKS.
20.9.42. 9.00 P.M.	Complain of sore throat for 7 days, diarrhoea for 4 months, eczema of scrotum for 2 months, pains in the chest, swelling of ankles for 3 months. Also had pains in the legs for 3 months with muscle cramps & tingling & numbness of feet & hands. ON EXAMINATION :- Large thick white membrane on right tonsil. Both sides of neck much swollen with painful glandular enlargement. Some angular stomatitis & smooth tongue. Heart sounds appear normal. Knee & ankle reflexes present & equal. Plantar responses flexor.	Walking.
11.30 P.M.	Appear to be in no particular distress till 11.30 P.M., when he called for an Orderly. When the Orderly reached his bedside he was choking. The Orderly Medical Officer saw him and performed a rapid tracheotomy.	
11.50 P.M.	Patient died.	
Conclusion:-	Although there was no time for a Lab Report to be received, on his throat swab, it is evident from the condition of his throat that he had Diphtheria. His history strongly suggests Beri-Beri.	

G. F. Harrison.
Major --- R. A. M. C.
Medical Specialist.

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00044

CASE NO.	775.	NAME OF DIAGNOSING DOCTOR	DOCTOR.	Major. J. Durran, H.K.V.D.C.			
UNIT	R. R. C.	NATIONALITY.	Canadian	NAME AND RANK.	Rifleman: BOUDREAU, S.		
NAME of DISEASE	1. Dysentery. 2. Intestinal Haemorrhage. 3. Broncho Pneumonia. 4. ~~Heart Failure.~~			DATE:- ADMITTED	11/9/42	DATE.- ~~DISCHARGED~~	25/9/42 DIED

DATE.	TREATMENT.	REMARKS.
Sept.11.	General condition fair. Frequent stools, blood and mucus. Beri-beri neuritis. Vit. B.	Fed.
Sept.12.	F.O. 11 to 16 hrs. Tret 0 Solu.Dagenham	
Sept.13.	General condition poor. Pulse. Bo.+++ SoluDagenham. Attacks in night. Poor rapid pulse. Cold Sweat. Internal Haemorrhage ?	
Sept.14.	B.O. 5 to 6 in night. Soludagenham. Pulse:112. Melaenae.	
Sept.15.	Vomited blood in night. Melaenae. Soludagenham. ? Bleeding Peptic plus. Alkaline powder 2 hourly 2 hourly liquid food alternating.	
Sept.16.	Still Melaenae. Restless. Thirsty. Pulse 108. Temp.100. Soludagenham.	

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CASE NO.

No.	775		Name of Diagnosing Doctor		Major I. Dunn H.K.V.D.C.
Unit	R.A.M.C.	Nationality	Canadian	Rank / Name	Pte. S. BOUDREAU
Name of Disease	1. Dysentery 2. Intestinal Haemorrhage 3. Broncho-Pneumonia 4. Heart Failure	Date Admitted	11.9.42	Date Discharged	Died. 25/9/42.

Date	Treatment	Remarks
23.9.42	Transferred from Dysentery Ward to Medical Ward. Diagnosis: 1. Dysentery 2. Intestinal Haemorrhage 3. Broncho - pneumonia 4. Heatt Failure. Is still incontinent of Urine & Faeces (No blood or mucus in stools). Apetite fair. No vomiting -- no pain. On examination: Is very pale. Tongue & Throat are clean. Heart sounds are normal. Lungs - some fine crepitations at bases. Blood Pressure 110/70. Capillary Resistance Test is negative. Treatment: Food -- All extras including milk. Thiamin Chloride. 10 mgm every day.	
24.9.42	Says he feels "not too bad". Is still incontinent almost hourly.	
25.9.42	Slept fairly well but his general condition this morning was poor. Pulse has become very rapid. Is still incontinent. On Examination: Tongue moist; appears dazed; persistent moaning. Looks very thin & exhausted. Cyanosis & diffuse subcutaneous, capillary haemorrhages in the skin of the sternum. Heart sounds are normal; lungs as before. Treatment: Change to sulphathiazole 4.0 grams per day. Nicotinic acid 150 mgms per day. 2:30 p.M. 20 ccs of 50% Glucose given intravenously.	
3:00 p.m.	Breathing became slow. Pulse almost inperceptible. Appeared to be in a dying condition. He has been incontinent all day & has vomited twice. Treatment: 20 ccs of 50% Glucose given intravenously, as well as 30 mgms Thiamin Chloride intravenously. 1.7 ccs Coramine Subcutaneously.	
10:15 p.m.	Patient cyanosed, & in a state of collapse.	
10&20 p.m.	Patient Died.	

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CASE NO.

No.			Name of Diagnosing Doctor		
Unit		Nationality		Rank	
				Name	
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks

Results of the Post Mortem Examination on the body of the Late Rfn. S. Boudreau

Trachea - Clean.

Lungs - Both Lungs, especially the left, showed large numbers of well-marked broncho-pneumonic patches, which had the appearance of Tuberculosis. Several smears were taken from these patches. No tubercle bacilli were found. There were no predominating organisms.

Pericardium - No excess of fluid.

Heart - Weight - 9 ozs. There was a large premortem clot in the right ventricle. In other respects the Heart was Normal.

Liver - Normal.

Pancreas- Very hard & gritty to the touch.

Kidneys - Normal.

Spleen - Small. Weight 4½ ozs.

Gut - Descending Colon - About 14" were of a dark, greyish-black colour, almost necrotic, the tissue being very friable (evidence of old haemorrhage), no ulcers were seen. There was no other evidence of Dysentery at the time fo death.

all Tissues - Were extremely pale (from thehaemorrhages).

Conclusion :

This Patient died from extreme Anaemia & heart Failure, the result of Intestinal Haemorrhage. He was also suffering from Broncho-pneumonia, which may have been Tuberculosis, although no laboratory evidence of this is available.

G. F. Harrison

Major --- R.A.M.C.

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6007

CASE NO. 686 NATIONALITY - Canadian NAME - ABEL, F.J.
RANK - Sergeant

DISEASE - Cardiac Beri-Beri DATE ADMITTED 5/11/42 DATE DISCHARGED Died 30/11/42

Nov. 5 Patient was admitted with complaint of severe loss of weight, pains in lower extremeties, generalized weakness, loss of appetite of 2 months duration.
Bed rest - Full diet and extra diet.

Nov.20 Patient has shown no improvement with extra feeding and rest. Still has marked anorexia, difficulty in sleeping due to foot pains.
Bed rest - Fulldiet and extra diet.

Nov.23 Patient felt weaker to-day and vomited twice.
Bed rest - Full diet and extras. Sedative at night

Nov. 25 Patient has marked nausea to-day and vomited 4 times. And 4 loose stools during the day.

Nov. 26 Patient still vomiting and had six loose stools during the night. Also feverish; pulse slow and weak.
Transfer to "A" Ward
Complete bed rest. Potassium citrate ½ oz. q.3.h. x 4
Aspirin ½ oz. q. 3. h. x 4
Light diet with milk and tomatoes.
Push fluids in small sips.
Sedative at night. Thiamin 20 mg.

Nov. 27 Patient very weak, vomiting controlled and diarrhoea less. Pulse very weak, 50 per minute.
Orders as before.

Nov. 28 Patient near death to-day. Pulse slow and weak. No vomiting. Only 2 stools in 24 hours but patient in obvious cardiac collapse and has hiccoughs.
Complete bed rest with bed pan and urinal. Pot. Cit. ½ oz. q.3.h. x 4 .
Full diet with extras; tomatoes and milk.
Push fluids. Thiamin 20 mgm.

Patient went downhill and died at 6:10 P.M.

Cause of Death - Cardiac Beri-Beri

MacReid, Capt

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60098

CASE NO. 584 NATIONALITY - Canadian NAME - OTGH, J.
RANK - Private

DISEASE - 1. Diphtheria, Faucial DATE ADMITTED 28/10/42 DATE DISCHARGED Died 28/11/42
2. Acute Enteritis

Oct. 28 Admitted to Diphtheria Ward from Carrier Compound with Faucial Diphtheria and Dysentery. Patient extremely emaciated (he had lost considerable weight in the past few months). Membrane on right tonsil. Had been very ill in Carrier Compound with dysentery, but rallied. Still having 8-10 movements in 24 hours.

Treatment Anti-toxin 5,000 units

Oct. 30 No membrane. Improved.

Nov. 1 Condition improved. 6 bowel movements in 24 hours.

Nov. 5 10 bowel movements in 24 hours with cramps and blood and mucous.
Treatment: Mag.Sulph ½ oz. c.l.h. x 4

Nov. 6 Slight improvement.
Treatment: Trional 1.6 gms.

Nov. 9 6 bowel movementsin 24 hours.

Nov. 11 Decubitus ulcers have developed on buttocks and over right scapula.
Treatment: Mattress and padded rings

Nov. 13 13 bowel movements in 24 hours.
Treatment: Trional, 2 tabs. Bis. Sol. 1 on. c.l.h. x 4

Nov. 16 No improvement. Bed sores healed.

Nov. 19 5 movements. Cramps ++ Treatment: Mist to abdomen. Sod. Bic. 1 oz. t.i.d., p.c.

Nov. 21 6 movements. Weaker. Pro nosis poor.

Nov. 23 Pulse 120. Marked weakness and increased emaciation.

Nov. 25 Somewhat dehydrated. Catarrhal conjunctivitis.
Treatment: Rock Saline. Eye wash c.4.h.

Nov. 27 8 movements. Pulse 114, irregular and weak. Incontinent by bowel. Dehydration increased.

Nov. 28 Moribund all day. Heart sounds distant, irregular and slow.

Died at 7:00 P.M.

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64009

CASE NO.

No.	891.			NAME OF DIAGNOSING DOCTOR	Mass.
UNIT	R.C.O.C.	NATIONALITY	Canadian.	PATIENT'S NAME	Cusson, B.M.
				RANK	Private.
NAME OF DISEASE	1.Diphtheria. (Lip & Mouth & Nasal.) 2.Heart Failure.			DATE OF ADMISSION	23/9/42.
				DATE OF DEATH	28/9/42. 3.30.P.M.

DATE	TREATMENT	REMARKS
23/9/42.	Complains of sore throat and a blocked nose for 7 days. On Examination: The whole of the left side of the face is swollen with oedema. The left-eye is closed. Inside the upper lip, there is a white, firm, adherent membrane, the throat, itself, is clean. Heart sounds are normal. Treatment: Hot dressing to face. Antiphlogistine to neck. Hot gargles. Thiamin Chloride 10 mgm daily.	Stretcher.
24/9/42.	The swelling has greatly increased. Treatment: Soludagenham 1 gram b.d. Repeat other treatment.	
25/9/42.	No Improvement. Treatment: Sulphathiazole 6.0 grams.	
26/9/42.	Slept poorly. Occasional vomiting. The oedema has now spread to the right side of the face & both eyes are closed. The lips have a gummy, exudate upon them. There is also a thick, purulent discharge coming down the left nostril. Treatment: Is on all available extras, including milk. Sulphathiazole 4.0 grams. Change to ice packs to face. (N.B.) - there is no suitable blood donor available.)	
27/9/42.	Appears quite lively in himself. Slept poorly. Some pain in midepigastric region for the last three or four days. Slightly less oedema of face. Heart sounds appear normal. Pulse rate fairly slow. There are small harmorrhagesin the skin under the right arm. Treatment: Try neo-spirarsen .45 grams intravenously. Ice water drip mask on face. Tannafax jelly to abrasions on nose, Sulphathiazole 4.0 grams.	
28/9/42. Morning.	Restless night. Slightly less oedema. Says he feels not too bad. Lab. Report on Swab of Membrane:- No Klebs Loeffler Bacilli or Vincents organisms found. Now says has had numbness of both hands since a few days before admission. He vomited last night & once this morning. On Examination : The whole face, especially left side, is grossly swollen with brawny oedema. Heart sounds appear normal but pulse rate has become much more rapid.(120). Treatment:- 11.30 A.M. - 20 ccs of 50% glucose intravenously.	
3.20 P.M.	Patient gave a few gasping breaths & tried to struggle in to a sitting position.	
3.30 P.M.	The Patient died quite suddenly.	

(G.F. HARRISON.)
Major - R.A.M.C. (Medical Specialist.)

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CASE No. (CONTD. NO.I.)

No.		NAME OF DIAGNOSING DOCTOR	
UNIT	NATIONALITY	PATIENT'S NAME	Cusson, B.M.
		RANK	Private.
NAME OF DISEASE		DATE OF ADMISSION	
		DATE OF DEATH	

DATE	TREATMENT	REMARKS

The Post Mortem Exam nation on the body of the Late Private CUSSON, B.M., R.C.o C., showed :-

---

The face and neck are greatly swollen. There is a white exudate on the upper eyelid of the left eye. The skin has peeled off the nose.

Trachea:- Just above the vocal chords, there is a small of thin membrane (Specimen taken for laboratory examination) The traches, generally, appears rather congested.

Lungs :- Are congested.

Heart:- The right auricula-ventricular valve is widely dilated, taking three fingers. The righ side of the heart, generally, is much dilated. Valves, otherwise, appear normal. Muscle, no gross abnormality detected.

Abdomen:- There is a fair amount of transcudate (Yellow fluid - some of which has clotted.) in the peritoneal cavity)

Liver:- Appears normal.

Kidneys:- Appears normal.

Spleen:- Normal. 3½ oz.

Conclusion:- Death was due to right sided heart failure, following upon diphtheria, which affected the upper lip & the left nostril.

(G.F. HARRISON.)
Major - R.A.M. C. -- Medical Specialist.

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00051

CASE NO.

No.	844			NAME OF DIAGNOSING DOCTOR	Major G.F.Harrison.
UNIT	W.G.	NATIONALITY	Canadian	PATIENT'S NAME	RAITZ, E.
				RANK	Private.
NAME OF DISEASE	Diphtheria (Throat) Internal Haemorrhages. Heart Failure.			DATE OF ADMISSION	22/9/42
				DATE OF DEATH	29/9/42

DATE	TREATMENT	REMARKS
22/9/42.	Admitted at 8.45.pM. complaining of sore throat, onset this morning. Throat very painful. On Examination: There is a membrance present on both tonsils. Heart sounds are normal. Ankle reflexes are absent. Treatment: Hot irrigations to throat. 10.mgm.Thiamin Chloride every day.	Stretcher.
23/9/42.	Feels the same.	
24/9/42.	Throat condition worse. Treatment: Sulphathiazole 4.0.grams. Lab Report on Throat Swab: No Klebs Loefflers Bacilli or Vincents Organisms present.	
25/9/42.	Neck is now greatly swollen on both sides. Heart sounds appear normal. Treatment: Sulphathiazole 4.0. grams. 0.45.grams Neo-spirarsen intravenously.	
26/9/42.	Says he feels better. Throat appears about the same. Lab Report on Throat Swab: No Klebs Loefflers Bacilli. Some Vincents Organisms. Treatment: Sulphathiazole 3.0.grams.	
27/9/42.	Neck is even more swollen. Uvula is becoming infected,too.	
28/9/42.	There is a hard, brawny swelling present on both sides of the neck. There is a grey, necrotic mass present on both tonsils & over the uvula. Treatment: Is on sweet drinks & milk. Repeat hot eusol irrigation to throat. (N.B.:-- there is no suitable blood donor avaible).	
29/9/42.	Slept poorly. Says he feels the same. Throat & neck condition as before. Heart sounds are obscured by friction fremitus over the praecordial area. (?dry pericarditis). coarse sounds present over both lungs. There are haemmorhagic patches in the skin on the right side of the neck. Lab Report on Urine:- Albumen present - - - Deposit contains tubular casts, epithelial cells and pus cells - -. Treatment:- Soludagenham 4.0.grams. Ice packs to neck.	
1:45.P.M.	The patient died.	

G. F. Harrison.
Major -- R.A.M.C.
Medical Specialist.

25008

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No.			NAME OF DIAGNOSING DOCTOR
UNIT		NATIONALITY	PATIENT'S NAME
			RANK
NAME of DISEASE			DATE OF ADMISSION
			DATE OF DEATH

DATE	TREATMENT	REMARKS

The Post Mortem on the body of the late H-6898 Pte. Raitz. E., Winnipeg Grenadiers, showed:

All tissues were very aenemic,

Trachea -- Below the vocal cords, the trachea showed a thin membrance, spreading down to the biforcation of the main bronchi (specimen taken for laboratory examination).

Lungs: -- There were large haemmorhages present in both lungs, more especially the right one.

Heart. -- Size very small. Premortem clot in right ventricle, otherwise nil abnormal found.

Pericardial sac -- Showed excess of fluid.

Liver -- Normal.

Spleen. -- Normal. (4.oz.)

Kidneys -- Normal.

There was some haemmorhagic standing of the mesentery.

Conclusion -- From the clinical condition, during life, and from the membrance present in trachea, it is evident that he was suffering from diptheria, although no œthological confirmation of this is available so far. He died from heart failure and from the haemmorhages, which were caused by the intense toxaemia.

G.F. Harrison.
Major--- R.A.M.C.
Medical Sepcialist.

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E5003 00053

CASE NO.

No.	796.			NAME OF DIAGNOSING DOCTOR	Major-G.F.Harrison. (R.A.M.C.)
UNIT	R.C.C.S.	NATIONALITY	Canadian.	PATIENT'S NAME	T. REDHEAD.
				RANK	SIGNALMAN.
NAME OF DISEASE	1.Membranous.Tonsillitis. (? Diphtheria). 2. Heart Disease. 3.Heart Failure			DATE OF ADMISSION	14/9/42.
				DATE OF DEATH	30/9/42.

DATE	TREATMENT	REMARKS
14/9/42.	6.00.P.M. Complains of sore throat for 1½ days. On Examination:- White exudate present on both tonsils. Heart... The first sound at the apex is reduplicated (? presystolic murmur). Treatment:- Hot irrigations to throat.	Stretcher.
15/9/42.	Feels shaky. Some diarrhoea-bowels opened 4 times to-day. Throat as before. Knee reflexes absent. LAB.Report on Throat Swab shows:- No Klebs Loefflers Bacilli or Vincent Organisms present. Treatment:- Mist.Bismuth-.Salicylate 1 oz. t.d.s.	
16/9/42.	Feels slightly better. Lab. Report on Throat Swab. No Klebs loefflers Bacilli or Vincent Organisms found. Lab. Report on Urine. No Albumen found. Blood Slide for Malaria. Negative. Treatment:- Is on all extras, including milk, sugar drinks. †††	
17/9/42.	Nose is very blocked. Stools normal now. Treatment:- Sulphathiazole 4.0 grams.	
18/9/42.	There is very little glandular reaction.	
19/9/42.	Left eye is becoming rather inflamed. Throat condition as before. Treatment:- Boric irrigations to eye. Sulphathiazole 3.0 grams.	
20/9/42.	Nose blocked but throat is improving. Treatment:- Sulphathiazole 3.0 grams. Coll.*alkalinus lotion to nose.	
21/9/42.	Dysentery started today. Bowels opened 4 time with blood and mucus. Throat appears clean. Nose still blocked. Treatment:- Soludagenham 2.0 grams.	
22/9/42.	Bowels not open. Treatment:- Soludagenham 3.0 grams.	
23/9/42.	Bowels not opened. Throat almost clean. Nose still blocked. Treatment:- Stop Soludagenham.	
25/9/42.	Throat is now perfectly clean.	
26/9/42.	Nose is clearer.	
30/9/42.	Pulse rate is gradually becoming more rapid. His general appearance has deteriorated. Although he says he feels "all right".	
Afternoon.	Pulse rate increasing. At times, he appears almost cyanosed.	
Evening:-	He slept till about 11.40 P.M. and asked for a urine bottle, took a series of deep breaths - the head being rigid and extended. Pulse rate had become extremely rapid. Breathing stopped. Artificial respiration carried out, but at 11.55 P.M. he died.	

(G.F.HARRISON).
Major - R.A.M.C. Medical Specialist.

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CASE No. CONTINUED. NO.I.

No.		NAME OF DIAGNOSING DOCTOR	
UNIT	NATIONALITY	PATIENT'S NAME	T. REDHEAD.
		RANK	SIGNALMAN.
NAME OF DISEASE		DATE OF ADMISSION	
		DATE OF DEATH	

DATE	TREATMENT	REMARKS

The Post Mortem on the body of the Late Signalman T. Redhead , R.C.C.S., showed. :-

****

Throat. - Clean.

Trachea. - Clean.

Lungs. - Some congestion of the bases only.

Pericardial sac. - No excess of fluid.

Heart. - Appears much enlarged. Weight 17 oz. The right side of the heart is much dilated. No abnormality seen on the valves, themselves. Large premortem clot present in right and left ventricles. Small patch of subendothelial staining (blood) of wall of left ventricle.

Abdomen. - There is much excess of peritoneal fluid (presumably a transudate.)

Liver. - Shows well-marked nutmeg appearance of chronic heart failure.

Kidneys. - Normal.

Spleen. - Tissue rather soft, otherwise normal.

Conclusion:- He died from heart failure. From the clinical examination during life and from the finding of a large heart at the postmortem examination, it would appear that he had mitral disease of some standing. He denied having had rheumatic fever at any time, so it is difficult to know for certain what was the aetiology of this condition. There were no symptoms of beri-beri or other deficiency disease. The throat condition had the general appearance of diphtheria but there was no laboratory evidence available to confirm this.

G.F. HARRISON?
Major - R.A.M.C.
Medical Specialist.

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55003

CASE NO 2.

No.	830		Name of Diagnosing Doctor		
Unit	R. C. C. S.	Nationality	Canadian	Rank	Lance Sergeant
				Name	WHITE, W. J.
Name of Disease	1.Diptheria. 2.Heart Failure.	Date Admitted	22-9-42	Date ~~Discharged~~ Death	25 -9-42.

Date	Treatment	Remarks
22-9-42	Admitted at 10.00 A.M. Diagosis-- Diphtheria -- Heart Failure. Admitted complaing of sore throat for about six days. Sore mouth for three months. Burning feet for three months. Diarrhoea for 8 days. Patient's Past History -- DysenteryJanuary for 12 days. Dysentery - March for 7 weeks. Dysentery four or five times since then. History Present Illness -- Sore mouth off & on for three months. Never really clear. Stabbing pains in feet, especially at night. Throat has not been very painful until last three days. Feet are very tender. On Examination-- Large thick, white membrance over left tonsil & on posterior wall of pharynz. Marked angular stomatitis present. Neck swollen on both sides with diffuse, brawny, oedematous, glandular swellings, which are very tender. Heart sounds are normal. Pulse rate slow & strong. Lungs, clear. Central nervous System-- Knee & ankle reflexes present & equal. Plantar responses flexor. Labaratory Report on Throat Swab: "No Vincents Organisms present. Diphteroids present, some of which resemble Klebs Loefflers Bacilli. Urine Tesr for Albumen -- Negative. Treatment: 10 mgm Thiamin Chloride subcutaneously & 30 mgms intravenously. Hot irrigations to throat. Antiphlogistine to neck. Sulphathiazole 6.0 grams. Sugar drinks † † † . All extras, including plenty of milk.	Stretcher
23-9-42.	No sleep. Can scarcely talk. Complains of difficulty in breathing. On Examination: Neck is much more swollen. Heart sounds are normal. Treatment: Repeat as before. Blood transfusion of 540 ccs of citrated blood from Pte Milord (a convalescent diphtheria case).	
24-9-42.	Says feels slightly better. Slept Well. Throat & neck as before. Treatment: Hot irrigations. ice packs to neck. 10 mgm Thiamin Chloride every day. Sulphathizole 4.0 grams.	
25-9-42 Morning	Says he "feels awful". Head feels as if it were bursting. Throat feels worse. Treatment: Repeat the same. Glucose 50% - 20 ccs given intravenously.	
7:45.	Appeared normal; i.e. same as morning. No difficulty with breathing; pulse rate only 100.	
7:50.	Suddenly, the Orderly noticed him shaking his head to indicate that he could not breathe. Tongue was pulled out. End of bed raised. He became rapidly very cyanosed. I happened to be outside the Ward & attended to him immediately, performing an immediate laryngotomy. A tube was inserted, & a free airway assured. Patient took a few more breaths, by the aid of artificial respiration but the heart slowed & finally stopped, & the Patient died at 8.00 P.M.	

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CASE NO 1.

No.				Name of Diagnosing Doctor	
Unit		Nationality		Rank	Lance Sergeant
				Name	WHITE, W. J.
Name of Disease		Date Admitted		Date Discharged	

Date	Treatment	Remarks
	Results of Post Mortem Examination on the body of the late Lance Sergeant WHITE, W.J. Greyish-white membrance on left tonsil. Trachea: Clean. No membrance visible. Lungs: Normal. Heart: Right side rather dilated. Otherwise nothing abnormal. seen. Spleen: Normal size but extremely soft. Liver: Normal. Kidneys: Normal. Conclusion: The Patient died from Diphtheria & Heart Failure. Signed: C. F. Harrison. Major, R.A.M.C.	

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CASE NO. 240 NATIONALITY - Canadian NAME - McLAUGHLIN, T.
RANK - Rifleman

DISEASE - 1.Diphtheria, Faucial
2.Acute Enteritis
3.Pellagra

DATE ADMITTED 5/10/42

DATE DISCHARGED 28/11/42 (Died)

Oct. 5 Admitted to General Hospital with superficial infections of skin of legs, and scrotum. Treated with pot.permang. dressings with some improvement. On 13/10/42 he developed a sore throat which on examination revealed a diphtheritic membrane, involving both tonsils and the uvula. Bilateral cervical lymphadenitis. Transferred to Diphtheria Ward 13/10/42.

Oct. 13 Treatment: Anti-toxin 2,000 units
Boric compresses to legs and scrotum

Oct. 15 Patient is <u>extremely</u> emaciated and feeble. Anorexia
Thorat same.

Oct. 17 Throat clear. No glands. Pot.permang. dressings to scrotum and legs.

Oct. 19 Enemic. Appetite somewhat improved. Legs and scrotum better.

Oct. 22 Condition improving.

Oct. 26 Moved to convalescent ward. Ulcers on legs well healed.

Nov. 9 Transferred to Dysentery Ward. Had had diarrhoea for 1 week accompanied by cramps. 17 bowel movements in last 24 hours. Blood and mucous in stool.
<u>Treatment:</u> Mag.Sulph ½ oz. q.l.h. x 4
Trianon 1.6 gms.

Nov. 11 7 movements. Cramps less. No blood or mucous. <u>Very</u> weak.

Nov. 13 3 movements. Considerable flatus. Soda Bicarb. 1 oz. t.i.d., p.c.

Nov. 15 No change.

Nov. 19 3 movements. Vomiting after meals. Mist.Brom. et chloral ½ oz. t.i.d.

Nov. 21 5 movements. Still vomiting. Mist.Brom. et Chloral ½ oz. t.i.d.
Push fluids.

Nov. 23 Very weak. Emaciation extremely marked.

Nov. 27 Has developed photophobia and haziness over the cornea of both sides. Angular stomatitis, and ulceration of mouth.
<u>Treatment:</u> Atropine drops both eyes, daily
Eyewash t.i.d.
Mouthwash t.i.d.

Nov. 28 Apathetic and extremely weak. Pulse feeble and slow.
Died at 11:30 p.m.

(Capt. R(illegible))

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CASE NO		NAME OF DIAGNOSING DOCTOR		RODRIGUES. A.M.	
UNIT	Dockyard Defence Corps	NATIONALITY	British	NAME AND RANK	COLLINS, John Private
NAME OF DISEASE	CHRONIC ENTERITIS	DATE ADMITTED	20.11.42	DATE DISCHARGED	5/1/43

DATE	TREATMENT	REMARKS
20.11.42	Admitted with Diarrhoea, Blood and Mucus in stools and fever. General condition poor - Pulse 120. Oleum Ricini given on admission.	Diet - Fluid.
21.11.42) to 24.11.42)	Trienon Tabs. 8 daily given and injection Strychnine on 24th. p.m. Stools turned semi-solid with no blood or mucus.	
25.11.42	Mag. Sulph. 2 oz. in morning.	Diet - Full.
26.11.42) to 30.11.42)	Ferri. Sulph. Tabs. given 4 daily (3 gr. tablets), and Calcium Lactate gr. 10 t.d.s.	½ pint milk added to diet.
1.12.42) to 10.12.42)	General improvement but still some dyspepsia present and weakness. Mist. Anti-Acid contains Mag. Carb. and Sodi. Bic. given daily. Stools continue to be normal.	
11.12.42) to 18.12.42)	With slight improvement in appetite and increased intake of fats some diarrhoea recurred. Bismuth Salicyl given 7½ gr. t.d.s. Thiamin injections commenced 20 mgms every other day.	
19.12.42) to 22.12.42)	Blood and Mucus again known so M & B Tabs. given G. 2 daily for 3 days with cessation of symptoms.	
23.12.42) to 25.12.42)	Appetite good but still very weak.	Marmite in addition to milk and full diet.(1 oz. daily)
26.12.42	Some cough (light bronchitis). Mist Expectorant ½ oz. t.d.s. and Shark Oil 4 drops daily.	
27.12.42) to 31.12.42)	Cough quite hacking - loss of appetite and some headache at night - but no temp.	
1.1.43) to 2.1.43)	General ~~xxxxxx~~ malaise. Temp. 100. Stools diarrhoeaic - no sleep - Chlor. Hyd. gr. 10 at bedtime.	
3.1.43.	Collapsed 1.30.p.m. following stool - blood and mucus present. Injection Camphor 1½ gr. in 2 c.c. Oil. Injection Trienon 4.c.c. and 1 Pint Intravenous Saline with Glucose 2.30.p.m. 7.15.p.m. Injection Trienon 4.c.c. and Injection Camphor 1.c.c. Pulse 120. Incontinence faeces and urine.	Diet reduced to fluids only. F.M. 1 pint.
4.1.43	Passed restfull night. No incontinence. Pulse 110. Condition still poor being semi-conscious. Injection Trienon 2.c.c. Injection Camphor 1.c.c.	

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CASE NO		NAME OF DIAGNOSING DOCTOR		RODRIGUES, A.M.	
UNIT	Dockyard Defence Corps.	NATIONALITY	British.	NAME AND RANK	COLLINS, John. Private.
NAME OF DISEASE	CHRONIC ENTERITIS.	DATE ADMITTED	20.11.42.	DATE DISCHARGED	5/1/43

DATE	TREATMENT	REMARKS
4.12.43.	Intravenous saline and glucose 1 pint at 3 pm.. Not conscious and breathing poor. Slightly improved later. 1cc Camphor injection at 8 pm.	
5.12.43.	Slept fairly well during the night - noisy at intervals. Injection Camphor 1cc at 8 am. 2 pints glucose saline 10 am. Patient not conscious and breathing laboured, using the accessory muscles. Condition gradually worsened. Died 2.30 . p.m.	

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No.	501	NAME OF DIAGNOSING DOCTOR	Capt. M. Banfill
UNIT	The Royal Rifles of Canada	NATIONALITY Canadian	RANK Rifleman AND NAME IRVINE, G.
DISEASE	1. Faucial Diphtheria 2. Post Diphtheritic Paralysis	DATE ADMITTED 21/10/43	DATE DISCHARGED 10/1/43 (Died)

DATE	TREATMENT.	35/1635	REMARKS
Oct.21	Admitted with diphtheritic membrane on uvula and anterior pillars. Given anti-toxin 4,000 units. Hot gargles.		
Oct. 22	Membrane as above. Right submaxillary glands swollen.		
Oct. 23	Glands smaller. Membrane extended slightly.		
Oct. 25	Membrane persists on uvula.		
Oct. 27	There is still a thin membrane on the uvula and soft palate.		
Oct. 30	Membrane still persists though thin and easily detached.		
Nov. 2	Throat is clear. Patient is a ver emaciated and apathetic person with a pronounced malor flush. He has lost 100 lbs. weight in the past year, has no appetite and has not felt well for months. Physical examination shows a clear chest and nothing to explain malnutrition. He is put on all extra diet available , including two bottlesof milk a day and given thiamin 40 mgs. by injection weekly. Pulse 120		
Nov. 8	Slight attack of diarrhoea, given mag. sulph. and food stopped for the day. Nov. 9 - Diarrhoea better,appears very weak,P. 104		
Nov. 18	Occasional nocturnal diarrhoea, no appetite, no improvement in condition.		
Nov. 23	Complains of muscular pains in shoulders. Very weak. P.120		
Nov. 30	Diarrhoea is less frequent at night, otherwise no change in condition		
Dec. 9	Patient seems to be improving slightly.		
Dec. 12	Appetite very poor, emaciation extreme, complains of occasional return of fluids through nose and difficulty swallowing.		
Dec. 19	Is developing weakness of legs. Has considerable difficulty in walking.		
Dec. 29	Pulse is always difficult to feel, rate 140. Oedema of ankles.		
Jan. 2	Unable to walk, hands do not appear much weakened. Given cod liver oil after each meal as tonic.		
Jan. 7	Patient is becoming very helpless, Special orderlies put on to look after him. His emaciation is extreme. No desire to eat.		
Jan. 9	Developed diarrhoea during night. Is very weak. Pulse uncountable. Oedema face and legs. Very dehydrated.		
Jan. 10	Is in coma. Has not moved for 8 hours. Died at 11:30 A.M.		

HW 10/11/43

Jas Banfill. Capt

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No.	926	NAME OF DIAGNOSING DOCTOR	Capt. G.C. Gray
UNIT	Royal Rifles of Canada	NATIONALITY Canadian	RANK Rifleman AND NAME WILBUR, C.J.G.
DISEASE	1. Cardiac Beri-Beri 2. Chronic Diarrhoea	DATE ADMITTED 27/11/42	DATE DISCHARGED (Died) 17/1/43

DATE	TREATMENT	[illegible]	REMARKS
Nov. 27	Admitted with history of chronic diarrhoea over a period of two months. This became worse more recently. Day of admission had 15 watery stools. Occasionally cramps. No blood or mucous. Treatment: Mag. Sulph. 1 oz. q.l.h. x 4 Fluid diet		
Nov. 29	7 stools. Sulphanilamide 1 tab. q. 2.h. x 6. Heat to belly for cramps. Light diet.		
Dec. 1	7 stools. Sulphanilamide 1 tab. q.2.h.x6 Pot. Cit. 2 drams t.i.d.	t.i.d.	
Dec. 3	7 stools. Same treatment.		
Dec. 4	8 stools. Same treatment. Very little improvement. Full diet.		
Dec. 6	5 stools.		
Dec. 8	7 stools. Feels well. Complains of urgency.		
Dec. 10	7 stools. No urniary control. Treatment-Pot.Cit. 2 drams t.i.d.		
Dec. 12	6 stools. Mucoid stool. No urinary symptoms.		
Dec. 14	10 stools. Duculutus ulcers developing on each hip. Treatment- Pot. Permang. and peanut oil.		
Dec. 16	No change.		
Dec. 20	10 stools. Treatment- Bis.Sal. 1 ounce q.3.h. x 4		
Dec. 22	5 stools. Treatment- Bis.Sal. ½ ounce q.l.h. x 6		
Dec. 23	Edema of feet and hands. Treatment-Bis.Sal. 1 oz. q.l.h. x 6. Thiamin chloride 20 mgm. q.2.d. intramuscularly.		
Dec. 24	Increased swelling of feet, hands and now face. Treatment- Restrict fluids. Full bed care.		
Dec. 26	More edema.		
Dec. 28	Edema marked. Strotum enlarged, ascites present. Pulse rapid; Not of good quality.		
Dec. 30	No change.		
Jan. 2	Condition same. Not responding to thiamin chloride. Continue it.		
Jan. 6	Still having 5 to 8 watery stools per 24 hours. Edema slightly less. Bed sores over sacrum. Trt:Pot.Permang and peanut oil		
Jan. 10	Unimproved. Pulse still rapid and not strong.		
Jan. 12	8 stools. Very weak. Bed sores worse. Edema of scrotum less. Treatment- Tct. Benzoin Co. and castor oil to bed sores q.2.h.		
Jan. 14	Incontinent by bowel. Penis very edematous. Treat: Bis.Sal 1 oz. q.l.h. x 6. Pot.Permang. soaks to penis.		
Jan. 16	Condition worse. Heart irregular. Heart enlarged to percussion.		
Jan. 17	No improvement. Moribund most of day. Coramine 1.7 cc. given at 6:00 P.M. Ceased to breathe at 11:05 P.M.		

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No	P.O.W. No. 6666 1120	NAME OF DIAGNOSING DOCTOR	Major J.N. Crawford
UNIT	Royal Rifles of Canada	NATIONALITY Canadian	RANK Rifleman AND NAME MEDHURST, G.
DISEASE	Pellagra	DATE ADMITTED 17/1/43	DATE DISCHARGED (Died) 22/1/43

DATE	TREATMENT.	REMARKS
Jan.17	Admitted to hospital from lines. Complains of fever, numbness of face, trunk and legs, pain in chest. Examination shows low grade fever. Skin dry, with dermatitis at angles of noseand corners of mouth. Knee jerks diminished, vibratory sense diminished. Ataxic gait. Diagnosis: Pellagra with superadded fever.	
Jan.18	Afebrile. Appetite, improved. No other change.	
Jan. 19	No change.	
Jan.20	Became comatose during thenight. Eyes deviated to right. Knee jerks absent. Nicotinic acid 50 mgs. intramuscularly.	
Jan.21	Still comatose. Cheyne-Stokes respiration. Nicotinic acid 50 mgs. intramuscularly.	
Jan.22	Gradual decline all yesterday. Never regained consciousness. Died at 1:20 A.M.	

J.N. Crawford Major R.C.

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No.	P.O.W. No. 4603 789	NAME OF DIAGNOSING DOCTOR	Captain S.M. Banfill
UNIT	The Winnipeg Grenadiers	NATIONALITY Canadian	RANK Lance-Corporal AND NAME SINGLETON, W.B.
DISEASE	Chronic Diarrhoea	DATE ADMITTED 15/11/42	DATE DISCHARGED (Died) 22/1/43

DATE	TREATMENT.	REMARKS
Nov. 15	Admitted from the General Hospital with Diphtheria. He gave a long history of diarrhoea for several months; averaging 6 movements a day for the previous three months. He is emaciated with slight oedma of the face and legs. Membrane. Given Anti-toxin 5000 units.	
Nov. 16	Membrane.	
Nov. 17	Follicles only on both tonsils. Put on extra rations and thiamin injections.	
Nov. 19	Follicles on left tonsil only.	
Nov. 21	There is a spread of membrane on l. tonsil. Patient given repeat dose of 5000 units anti-toxin.	
Nov. 22		
Nov. 23		
Nov. 24		
Nov. 25		
Nov. 26	Throat clear for the first time.	
Nov. 27	Diarrhoea still 6 to 8 times in 24 hours. Puffiness of face. Slight oedema of the legs. Appetite poor. Thiamin every 2 days to be continued.	
Dec. 1	Oedema still noticeable.	
Dec. 5	Diarrhoea 8 times in 24 hours. Try Mag.Sulph ½ oz. q.2.h.x3	
Dec. 7	Cramps. Diarrhoea three times last night. Appetite fair.	
Dec. 8	Diarrhoea continues asbefore.	
Dec. 12	Oedema of face and ankles still remains.	
Dec. 13	Oedema of hands and face marked. No primary symptoms. Heart seems normal.	
Dec. 18	To be given extra proteins, meat or fish as available every day as Major Crawford thinks it possible oedema may be protein deficiency.	
Dec.23	There is shifting abdominal dullness but no fluid in the chest.	
Dec. 26	Vomited 6 times during the night. To begiven no food to-day.	
Dec. 29	Diarrhoea 8 times in 24 hours.	
Jan. 2	There is no improvement in oedema. Diarrhoea as before.	
Jan. 7	Diarrhoea twice at night.	
Jan. 10	Diarrhoea 4 times during the night.	
Jan. 11	Oedema of face and legs. Ascites as before.	
Jan. 15	Abdomen appears less tense.	
Jan. 19	Pulse. 72. Very slight cough. Oedema of hands and legs to knees, ascites. Chest clear. Very weak.	
Jan. 21	Diarrhoea 8 times during night. After supper felt better but very weak.	
Jan. 22	Unconscious since 6:30 A.M. Incontinence of faeces. Oedema of face and hands, legs to knees. Sticky rales in bases of lungs. Thiamin 15 mgs. intravenously. 40 mgs. subcutaneously. Did not recover consciousness. Died at 3:00 P.M.	

Capt. Banfill

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No.	745 P.O.W. No. 5152	NAME OF DIAGNOSING DOCTOR	Capt. G.C. Gray (RCAMC)
UNIT	The Winnipeg Grenadiers	NATIONALITY Canadian	RANK AND NAME Private Sumner, W.J
DISEASE	Pneumonia, Lobar	DATE ADMITTED 10/11/42	DATE (Died) DISCHARGED 25/1/43

DATE	TREATMENT.	REMARKS
Nov. 11	Patient admitted to hospital with history of marked loss of weight in past 6 months and "painful feet" for 2 or 3 mos. Patient very thin and emaciated. He was put at rest and during the next two months showed little improvement in his general condition. There was no weight increase and his "painful feet" became only slightly better.	
Jan. 8	Has developed numbness of chest, abdomen and hands with sense of constriction about chest. Treatment: Thiamin chloride 20 mgm. q.2.d.	
Jan. 24	Patient complains of cough, some respiratory distress and pain on right side of chest on coughing or deep breathing. Temperature 101 Pulse 140 Respiration 32. Physical examination shows diminished movement on right side, increased fremitus, diminished air entry and reles over right lower lobe posteriorly. Sputum became "rusty" during day. Treatment: Sulphapyridine 1 gm. q.2.h. x 5 Heat to chest Codeine Phosph. for pain.	
Jan. 25	Patient spent a poor night. Died at 10:00 A.M.	

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Admission No. 971. Name of Doctor. Major G.F. Harrison. R.A.M.C.

Unit. Attached R.E. Nationality. British. Rank & Name. Mr. Taylor. H.C.

Name of Disease. Cerebral Haemorrhage. Date of Admission. 28.10.1942.
Date of Discharge. DIED. 4. 1. 1943.

DATE.	COURSE of DISEASE & TREATMENT.	REMARK
28.10.42.	Admitted complaining of pain and swelling of feet, ankles and knees of both legs occoasionally for the last 16 years. Family History :- Father Died of bowel stoppage. Mother Died at 72 -- ? cause. Patient's Past History : Typhoid 1928. No other illnesses. History Present Illness: Pains and swelling tend to come on in wet weather -- do not appear to cause him much trouble now. Each attack lasts about ten days -- present attacks have lasted about 14 weeks. On examination : Appears very well. Left knee is swollen. Heart sounds normal. Knee and ankle jerks normal. Plantar responses flexor. Treatment : Rest in bed. Mist.Pot.Iod. grains 90 per day.	
6.11.42.	Only very slight pain now. Left knee still swollen.	
14.11.42.	Mild attack of diarrhoea. Treatment: Mist. Mag.Sulph. hourly for four doses.	
16.11.42.	Treatment: Bismuth-salicylate 1 oz. t.d.s.	
17.11.42.	Last night had a sudden acute pain in the back of the head, which gradually spread all over. Says he feels cold. Has no temperature. Onexamination: Urine contains a faint trace of albumen. Central Nervous system: Pupils equal and normal. All reflexes present and equal. Blood pressure 160/100.	
20.11.42.	Feels perfectly well. No headache. No pains aywhere. Knee all right. X-Ray Screening show heart normal in size and shape. Laboratory Report on Urine: Nil abnormal found.	
22.11.42.	Slight attack of fever. Blood slide---No malarial parasites found.	
23.11.42.	Right foot is swollen and tender. Has septic spots on ankle. Treatment : Hot dressings to foot. Blood Kahn Negative.	
1.12.42.	Has had another short attack of diarrhoea, for which he received Mist. Mag. Sulph. fourly for four doses.	
14.12.42.	Right ankle is oedematous. Blood Pressure. 170/95.	
23.12.42.	Says he feels weak and dizzy, if he does any strenuous work. Right ankle still swollen.	
1.1.43.	No pain or swelling. No complaints. Feels well.	
3.1.43.	Patient had been complaining of a Headache during the day and of difficulty with his eyesight. At 9.45 PM. he fell out of bed and was unconscious. On examination: Stertorous breathing. Unconscious. Both pupils very small but re-act slightly to light. No apparent paralysis or paresis of any limb. Knee jerks and ankle jerks very brisk. Both plantar responses are extensor. He was incontinent of urine and faeces. Resisted any form of interference and at first was inclined to be rowdy.	
4.1.43.	Patient remained unconscious throughout the night and breathing was stertorous. During one, short, lucid interval, during the night, he complained of Headache.	

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DATE.	COURSE of DISEASE & TREATMENT.	REMARK
8.00 AM.	On Examination : Lies inert on bed. Tongue half out of mouth. Cheeks puffed in and out. Left side of face appears to be paralysed. Left pupil normal size but eyelids are paralysed. Right pupil very small. Both pupils inactive to light. Corneal reflexes present on each side. No rigidity or spasticity, present in arms or legs. All deep reflexes very brisk. Abdominal reflexes absent. Plantar responses both extensor. There is a rhythmical spasm present in the left quadriceps extensor muscle. Blood pressure 220/110.	
9.00 AM.	Right pupil is enlarging.	
10.00 AM.	Breathing became slower and slower.	
10.15 AM.	Breathing stopped and Patient died.	

(G.F. Harrison).
Major R.A.M.C.
Medical Specialist.

POSTMORTEM EXAMINATION ON THE BODY OF THE LATE Mr. H.C. Taylor.

Brain : The membranes around the brain were firmly attached to the skull, making separation of the brain very difficult. There was a large haemorrhage 3" x 3" over the left parietal region of the brain behind the Rolandic sulcus. The brain substance was considerably damaged by this haemorrhage.

The brain stem, in the region of the pons, contained several small haemorrhages.

Lungs: Normal.

Heart: Left ventricle very thick. Weight 15½ ozs. Valves--normal. Aorta--normal.

Stomach: Dilated.

Liver: Normal.

Conclusion: The Patient died as a result of a cerebral haemorrhage. (Age 59).

(G.F. HARRISON).
Major. R.A.M.C.
Medical Specialist.

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ADMISSION No. 1139 NAME of DOCTOR. Major G. F. Harrison R.A.M.C.

UNIT. H.K.V.D.C. NATIONALITY. Portugese RANK. C. S. M.
NAME. BRITTO, H. M.

NAME of DISEASE. 1. Malaria (Clinical)
2. Hydronephrosis
3. Anaemia

DATE of ADMISSION 23-1-43
DISCHARGE. Died 31-1-43

DATE.	COURSE of DISEASE & TREATMENT	REMARKS.

23-1-43 Admitted complaining of w eakness. Nothing else.

Patient's Past History:
1. Dysentery -- November, 1942.
2. Diarrhoea -- Intermittently since then.
3. Wet Beri-Beri -- June, 1942.
4. Much flatulence but otherwise has been healthy.

History Present Illness:

Had sore tongue in July, August & September but not now. Also [illegible] for the same period. Has had occasional tightness across the chest for several weeks but this is not marked. Chief complaint is general w eakness--especially in the legs.

On Examination:

Face appears rather puffy.
There is oedema of both feet.
Eyes -- normal.
Mouth -- clean.
Tongue -- rather smooth.
Gums -- in rather poor condition.
Small bedsore on buttock.
Marked anaemia.
Pulse Rate -- 104.
Heart sounds are normal but are weak in quality.
Blood Pressure -- 80/50.
Lungs -- clear.
Abdomen appears swollen. There appears to be some slight, shifting dullness (? fluid).
Central Nervous System:
Power: Arms, rather weak; also, legs.
No numbness anywhere.
Reflexes: Knee jerks diminished on both sides.
Ankle jerks absent.
Sense of vibration diminished in legs up to hips.
No inco-ordination of arms or legs.

Treatment: Yeast drinks. Thiamin Chloride 40 mgms subcutaneously every 4th day. Recumbent position in bed. General nursing. Attention to bedsore. All available extras.

24-1-43 Slept at short intervals. Feels slightly better.

25-1-43 Laboratory Report on Blood:
Red Blood Count 2,030,000. Haemoglobin -- 40%.
Color Index -- 1.0.
Blood Slide -- No malarial parasites found.

Treatment: Iron tonic t.d.s. Vitomalt (own supply). All available extras including milk.

26-1-43 Slept four hours. Has much flatulence. Temperature 102.4°. Stools are loose & light colored. Spleen not palpable.
Blood Slide shows no malarial parasites present.

Treatment: Charcoal.

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DATE.	COURS of DISEASE & TREATMENT.	REMARK.
27-1-43	Still running an intermittent temperature. Sleeps poorly. Heart sounds are stronger. Treatment: Quinine grains 30 per day.	
28-1-43	Feels better.	
29-1-43	Sleeping better.	
30-1-43	Temperature rose to 105°. Blood Slide -- No malarial parasites found. Has slight headache. On Examination: No further physical signs found. Treatment: Quinine grains 40 to-day.	
31-1-43	Pulse was weaker at 8:00 P.M. last evening. Did not sleep well. Between 2:00 & 3:00 A.M., he became noisy & was talking wildly. Pulse, much weaker. The Orderly Medical Officer was sent for. Sedative ordered and patient slept. This morning Patient appears semi-comatose, respirations normal, pulse rate normal. Heart -- Gallop rhythm present. Treatment: Diethylamide of Nicotinic Acid 1.7 cos given intra-muscularly. End of bed raised on chairs. Urine contains no albumen.	
1:00 P.M.	Patient's pulse became weaker through the morning. He did not return to consciousness and at 1:00 P.M., he died.	

Post Mortem Report on Examination of the boyd of the late C.S.M. Britto, H.M., H.K.V.D.C.

No swelling or oedema present.
Lungs -- Normal.
Pericardial fluid increased. ++
Heart -- Small. Weight 7¾ oz. Muscle & valves normal.
Abdomen -- There was about a pint of fluid in the peritoneal cavity.
Spleen -- Appeared slightly enlarged.
Liver -- Normal
Kidneys -- Left: Much enlarged. Weight 7½ oz . Large clusters of cysts present in the upper pole, which were not connected with the pelvis of the kidney. The capsule stripped easily. Pelvis appeared rather dilated. The substance of the kidney tissues appeared slightly shrunken.

Right: Also large. Weight 8 oz. A condition of hydro-nephrosis was present. There were fairly large cystic dilatations, which ate into the calyces of the kidney. The cortex and medulla were much shrunken in consequence.
Stomach & Gut appeared normal.

Conclusion: The presence of such a marked degree of anaemia, together with the intermittent temperature, rising on one occasion to 105°, pointed to a clinical diagnosis of Malaria, although no parasites could be found.. For this he received Quinine in adequate quantities. There would appear to have been some degree of Avitaminosis B--possibly derived from the long history of diarrhoea. The condition of his kidneys was grossly abnormal. His condition, on admission to Hospital, was very poor, indeed, and he was not expected to live.

(G. F. Harrison)
Major ~~R.A.M.C.~~
Medical Specialist

第二分遣所

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Admission No. 1037. Name of Doctor. Major J.D. Fraser. R.A.M.C.

Unit. Royal Scots. Nationality. British. Rank. Sergeant. Name. O. McAlpine.

Nature of Disease :- Avitaminosis. Malaria. (MT). Cellulitis of Back. Date of Admission. 26.11.1942. Date of Discharge. 10.2.1943.

DATE. 26.11.42. COURSE OF DISEASE AND TREATMENT. REMARKS.

AGE. 43. BEGINNING OF SYMPTOMS. (DATE).

I. DERMATITIS.

ERYTHEMA. VESICLE. BULLA. DESQUAMATION.

FACE.
NECK.
ARMS.
HANDS.
PERINEUM. Scrotal Eczema. Tinea Corporis.
LEGS.
FEET.

II'.

FOLLICULITIS.
BLEPHARITIS.
STOMATITIS. Angular Stomatitis.
GLOSSITIS. Smooth Glazed Tongue.
GINGIVITIS.
PHARYNGITIS.

II. GASTRO-INTESTINAL.

DYSPHAGIA.
NAUSEA.
SENSATION OF EPIGASTRIC CONSTRICTION.

III. NERVOUS.

HEADACHES.
INSOMNIA. Insomnia.
DELIRIUM.
MANIA.
TREMOR.
PARASTHESIA.
DEEP REFLEXES.
VISION. Numbness of Body and Feet. Leg reflexes exxagerated. Vision. - deterioration slight.

IV. BLOOD AND BLOOD PRESSURE.

Blood pressure. 152/110. H.G. Tachycardia.

V. TREATMENT.

Avitaminosis. Normal Diet. Extras. Thiamine Chloride. Sedatives. Mist Bromide and Chloral.
Malaria. Quinine Sulph.
Cystitis. Sulphapyridine. (Trianon). Mist. Pot. Cit.
Cellulitis of Back. Sulphapyridine. (Trianon).

VI. CONCLUSION.

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Sgt. O McAlpine

DATE.	COURS of DISEASE & TREATMENT.	REMARK
3.12.42.	Since admission sleeping poorly, manages to have 2 - 3 hours sleep. Sensation in feet now that of pins and needles, when no shooting or aching pains.	
8.12.42.	Aching in all joints. Temperature. Blood slide. Negative. No spleen. Aspirin grs. X. t.i.d.	
13.12.42.	Blood slide. M.T. rings all forms. Quinine therapy started.	
14.12.42.	Sudden attack of faintness. Pulse rapid and weak. Vomited green sour fluid. Small sore over coccyx.	
16.12.42.	Still vomiting. Passing urine. Has not passed urine. Catheterisation.	
21.12.42.	Passing urine frequently and naturally. Burning pain on passage. Rigor. Urine contains pus and R.B.C. Sulphapyridine (Trianon). started.	
24.12.42.	Not vomiting. Oedema still present. Temperature settled. Stop Trianon.	
27.12.42.	Slightly jaundiced. Oedematous. Liver enlarged and tender. Sweating freely; passing urine.	
4.1.43.	Slight fever. Shivering.	
7.1.43.	Left buttock swollen, oedematous, red.	
11.1.43.	Buttock still swollen. Swinging temperature. Trianon started.	
14.1.43.	Abscess of left buttock opened. Discharging freely.	
17.1.43.	Wide sloughing of tissues and subcutaneous layer.	
19.1.43.	Blood transfusion. 350 ccs.	
22.1.43.	General condition slightly improved. Abscess of buttock now cellulitis of back, discharging freely.	
28.1.43.	Little amounts of serous discharge from buttock. Stop Trianon.	
4.2.43.	Developing cough. Old Emphysema. Mild Bronchitis.	
8.2.43.	General condition much deteriorated. Taking small amounts of food spasmodically.	
10.2.43.	Had attack of choking, inability to expel purulent spit. General condition very much poorer. 10.30 p.m. D.H.D.	

J Brown
Major R.A.M.C.

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11008

ADMISSION No. 1151 NAME of DOCTOR. Major G. F. Harrison R. A. M. C.

UNIT. D. D. C. NATIONALITY. British RANK. Private NAME. Parton, William.

NAME of DISEASE. 1. Hydrocephalus 2. Avitaminosis B DATE of ADMISSION 23-1-43 DISCHARGE.

DATE.	COURSE of DISEASE & TREATMENT	REMARKS
23-1-43	Admitted complaining of general weakness. Patient's Past History: Dysentery, January, 1942. Arthritis, February to August, 1942. History, Present Illness: No. Diarrhoea. No Blurred Vision. No pains in hands or legs. Has had numbness of legs for some time. Also complains of inability to hold his urine for the last three nights. On Examination: Thin and emaciated. No anaemia. Tongue rather smooth. Lips shiny. Whole body from head to foot is covered with an exfoliative dermatitis. This started as septic sores on the backs of the hands in October and gradually spread to the rest of the body. The hands are covered with a thick, dirty grey mass of thickened epithelium several millimeters thick. The whole skin is peeling gradually. Heart sounds normal. Lungs clear. Mental condition appears normal. Abdomen--All abdominal palpable. No loss of power in arms or legs. No tenderness of calves. Knee jerks and ankle jerks are exaggerated. Treatment: Acne-base & castor oil ointment for skin. Thiamin Chloride 20 mgms every fourth day. Nicotinic acid 20 mgms intramuscularly per day. Yeast. All available extras including milk.	
28-1-43	Slight nausea and vomiting.	
30-1-43	Skin is gradually peeling and appears in better condition.	
31-1-43	Numbness has increased but he feels better in himself.	
6-2-43	Skin on the hands is still covered with thick, hardened crusts.	
7-2-43	Knee and ankle jerks are normal. Sensation of pinpricks is absent on arms and legs.	
10-2-43	This morning his manner was noted to be peculiar. Appeared dazed. He slept for the most of the morning and by the evening was his normal cheerful self.	
11-2-43	Slept well till 6:00 A. M., when he began moaning. He became unconscious. The Orderly Medical Officer was sent for and he was placed on the Dangerously Ill List.	
8:00 A.M.	On Examination: Is lying in bed--eyes half-opened--pupils equal, regular, don't react to light. Cornea insensitive. Legs and legs are rigidly extended and rather difficult to flex. Right arm and right leg appear rather more rigid than the left. Cheyne-Stokes respirations. Pulse feeble and slow. Heart sounds distant but normal. Blood Pressure 110/?. Lungs--Crepitations present at bases. Reflexes unobtained. Plantar responses on both sides are extensor.	
11:40 A.M.	Patient died.	

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DATE.	COURS of DISEASE & TREATMENT.	REMARK.

Report on the
Post Mortem Examination of the Body of the Late Pte. Paxton, W.

Brain-- Dura-mater appeared normal. Pia-arachnoid membranes were thickened and had a milky appearance in consequence, which was more marked over the frontal lobes and to a less extent at the base of the brain. The ventricles were greatly dilated (hydrocephalus). There was much excess of normal fluid, which was clear. There was no evidence of a brain tumor nor was there any visible evidence of an obstruction in the ventricular system.

Heart-- Size, normal. Valves, normal. Weight 7 oz. Atheromatous changes at the beginnings of the aorta and in the descending aorta.

Lungs-- Both lungs showed red hepatization in the lower lobes. A [illegible] fluid exuded from the cut surfaces of the lungs generally.

Abdomen: Spleen -- Extremely small. Weight 1½ oz.

Liver -- Normal.

[illegible] Kidney -- Structure appeared rather abnormal. Very small. Weight - 2¾ oz.

[illegible] Kidney - Weight 3 oz.

Conclusion: This case is remarkable in the fact that, although there was a marked degree of hydrocephalus, there were no symptoms whatsoever pointing towards this condition. No Kahn test was performed, so it is difficult to know what the aetiology of this condition was.

(G. F. Harrison)
Major --- R. A. M. C.
Medical Specialist

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E1008

CASE NO. 112

17

PRESCRIPTION FORM.

No. 5059 Rank Gunner Name NUR MOHAMMAD. Unit H.K.S.R.A.

Medical - Officer i/c :- Jemadar N.B.Pasary, I.M.D.

Date	Prescription.	Diet.
13/2/43	Mist. alkaline 1 oz. T.D.S. Enema of soap and water stat. Mist. Quinine 1 oz. given in the evening.	1 Bottle of fresh milk (10 Oz)
14/2/43.	Glucose water ad lib. Liver extract given I.M. 2 c.c.	--- " ---
	Quinine ~~S~~ bihydrochloride 10 grs. given I.M. Boroglycerine paint in mouth and gums.	
(9 P.M.)	Glucose 25 gms in 50 c.cs. given I.V.	
	Trianon 5 c.c. I.M.given.	
(11.30)	Trianon 5 c.cs given I.M.	
	Hot water bottles to feet.	
	Adrenalin half c.c. S.C.	
15/2/43.	Patient expired at 2.30 A.M.	

Jemadar, I.M.D.,
comdg. Dai Ni Bunken Sho.

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00174

CASE NO		NAME OF DIAGNOSING DOCTOR	Capt. G. T. Balean.		
UNIT	4 HKVDC.	NATIONALITY	BRITISH.	NAME AND RANK	HIGGINS, JAMES. Bombadier age 49.
NAME OF DISEASE	Retro pharyngeal abscess Suppurative inhalation Pneumonia	DATE ADMITTED	11. 2. 43.	DATE ~~DISCHARGED~~ DIED.	15.25 21. 2. 43

DATE	TREAT MENT	REMARKS
17/12/42		Diphtheria and Quinsy 27. 12. 42.
20/12/42.		Quinsy burst 30/12/42.
22/1/43.		Developed a conf. 22. Jan 43.
29/1/43.		Difficulty in taking food 29/Jan 43.
5/2/43.		Tendency to inhale food 5/2/43. and developed signs of Laryngeal paralysis.
11/2/43.		Discharged from Diphtheria 11/2/43.
	Atrophin gr 1/100 four hourly Coramin given 2 a.m.	Developed a left basal bronchitis and dubious pleural sub.
12/2/43	Atrophine gr 1/100 Morphine gr 1/4 2 pm.	12/2. Pulse weak and irregular. Not sleeping. Still has very little sleep
13/2/43.	Atrophine 1/100 Morphine gr 1/4 10 pm.	13/2. Condition slightly better pulse 76. respirations 20.
14/2/43.		14/2. Brought up about 1 ounce of thin yellow staphylococcal pus. Not foul smelling. Pus was inhaled. Specimen examined by Major Gray Contained Pus epithelial cells, Staphylococci Respiration rate 46. after inhalation but after postural drainage returned to 20.
	Sulfapyridine 0.5 gm given total 3 gm per day Tube feeding instituted by Catheter. No food allowed except by tube. Postural drainage for lungs when distressed (about 2 hourly).	15/2. Pus evacuated from chest several times pulse 110 Resp 32
15/2/43		16/2. Much pus from chest Condition poor.
16/2/43	Camphor in olive oil gr 3. injected t.i.d.	18/2. Mental condition poor Rambling
18/2/43.		21/2. Died Suddenly at 1525 hours
24/2/43.		

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CASE NO. 135

20

PRESCRIPTION FORM.

Regtl. No. 5071 Rank Gunner Name LAL KHAN Unit H.K.S.RA.

Officer i/c:- Jemadar Kartar Singh, I.M.D.

Date.	Prescription.	Diet.
28-2-43.	CasterOil 1 oz.with chlorodine 5 min.stat.	-
1-3-43.	Mist.Saline 2 drs. every hour for six doses.	1 Bottle of fresh Milk daily.
2-3-43.	Treatment continued.	
3-3-43.	Mist Saline 2 drs. four hourly.	"
4-3-43.	Mist. Quinine 1 oz.T.D.S.	"
5-3-43.	Mist.Expect stim. 1 oz T.D.S.	"
6-3-43.	Mist. expect stim. 1 oz T.D.S. Codliver Oil emulsion 1 oz B.D.	"
7-3-43.	Codliver Oil emulsion 1 oz T.D.S. Mist.stim. 1 oz four hourly.	"
8-3-43.	Patient died at 7.30 A.M.	

Jemadar,. I.M.D.,
Commanding Dai Ni Bunken Sho.

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PRESCRIPTION

No. 7584 RANK Sepoy NAME Abdullah Khan.

UNIT 5/7th Rajput Regt. OFFICER i/c Dr. N.B.Pasary.

DATE	PRESCRIPTION	DIET
30.10.42	Mist. saline 2 drms. hourly.	
31.10.42	Mist. saline 2 drms. every hour for six doses.	O.D.
1.11.42	Mist. saline 2 drms. 4 hourly.	"
3.11.42	Mist.Iron tonic 1 oz t.d.s.	" with 5 ozs.of Milk.
12.11.42	Mist. Quinine 1 oz t.d.s.	"
13.11.42	Treatment repeated.	"
14.11.42	Mixt. HYPER tonic saline 3 pts.given I.V.	" with 8 ozs.of Milk.
	Mist. saline 1 drm. hourly.	"
16.11.42	Mist. Bismuth 1 oz b.d.	"
17.11.42	Carbon.Tetrachloride m.40 Oleum Chinapodium m.16 in liquid parafin 1 oz given by mouth.	"
	Thiamine ½ c.c. s.c. for six doses.	"
25.11.42	Emulsion Cod Liver oil 1 oz t.d.s.	" with 10 ozs.of Milk.
	Mist. Iron Tonic 1 oz.b.d.	
3.12.42	Olium Chinapodium course reapeated.	" with 12 ozs Milk.
4.12.42	Mixt. Iron Tonic and emulsion Cod Liver oil 1 oz t.d,s.	"
14.12.42	Trianon 4 c.c's I.V. and Tablets Trianon 16 in 24 hrs.	"
15.12.42	Treatment repeated	" With 16 ozs of Milk.
16.12.42	Tablets Trianon 12 in 24 hrs.	"
17.12.42	Mist.A.P.C. 1 oz.	"
18.12.42	Mist.Potas.Citras 1 oz b.d.	"
20.12.42	Mist.Iron Tonic 1 oz b.d.	" With 20 Ozs
24.12.42	Trainon 4 c.C's I.V. and tab.trianon 12 a day.	" of Milk.
25.12.42	Treatment continued.	"
1.1.43	Mist.Iron Tonic 1 oz b.d.& Emulsion Cod Liver Oil 1 oz t.d.s.	"
12.1.43	Carbon Tetrachloride & Olium Chinapodium course repeated.	"
13.1.43	Mist.Iron Tonic 1 oz b.d.	" With 25 Ozs
	Cod liver oil emulsion 1 oz t.d.s.	of Milk.
22.1.43	N.A .B. 0.30 g.m. I.V. given.	"
23.1.43	Mist.Iron tonic 1 oz b.d.	"
	Mist.Ser. 1 oz b.d.	"
13.2.43	Olium chinapodium course repeated.	" with 30 Ozs
18.2.43	Mist. Cal. Lic. 1 oz t.d.s.	" of milk.
26.2.43	Mist.Iron Tonic 1 oz b.d.	"
3.3.43	Trianon Tabs. 4 four hourly.	"
5.3.43	Treatment repeated.	"
7.3.43	Trianon Tabs. 4 b.d.	"
9.3.43	Mist.expect.serd. 1 oz. t,d,s.	"
	Mist. Cal.Lic. 1 oz t.d.s.	"
14.3.43	Adrenaline H.C.F. ½ c.c. given s.c.	"
15.3.43	Patient expired at 8.1.5.A.M.	

Omkar Singh
JEMADAR, I.M.D.
Comdg. DAI NI BUNKEN SHO.

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ADMISSION No. 1253 NAME of DOCTOR Major G. F. Harrison R. A. M. C.

UNIT. R. R. C. NATIONALITY. Canadian RANK. Lance-Corporal NAME. Chapman, F.

NAME of DISEASE. 1. Typhoid Fever 2. Perforation of Gut & Acute Peritonitis 3. Malaria - B. T. Fresh DATE of ADMISSION 5-3-43 DISCHARGE DEATH 14-3-43

DATE.	COURSE of DISEASE & TREATMENT.	REMARK
5-3-43	Camp Medical Officer says: "27-2-43 Admitted to Camp Hospital, having had fever for 4 days. Temperature 101.3. No Spleen palpable. 28-2-43 Temperature 101.3. Blood Slide - B. T. gametocytes. Quinine-Hydrochloride grains 10. 1 & 2-3-43 Temperature 101.3. Quinine-Hydrochloride grains 10. 3-3-43 Felt better. 4-3-43 Temperature 101." - - - - - - - - - - - - - - - - - On Admission: Complains of lack of appetite & vomiting after meals. Patient's Past History: Dysentery September to December, 1942. No further dysentery since then. Sore feet in September. History Present Illness: About 7 days ago, found he couldn't eat. Has vomited after nearly all meals for the last three or four days. No sore mouth or sore throat. No cough. No indigestion. Feels chilly at times. No numbness. Vision normal. On Examination: Mouth & tongue, clean. Heart sounds normal. Lungs, clear. Abdomen: Spleen palpable 1 finger's breadth below the costal margin. Central Nervous System: Knee & ankle reflexes present and equal. Treatment: Quinine grains 30 per day.	
7-3-43	Feels better. Has stopped vomiting.	
8-3-43	Says "Feels better". Temperature is still showing some alternation.	
9-3-43	Says "feel not too bad". On Examination: Heart & lungs normal. Treatment: To have quinine grains 40.	
10-3-43	Temperature normal. Feels better but he has one to two stools per day, which are large and rather loose. Light-colored. No blood or mucus in stools. No abdominal pains. Laboratory Report on Urine: 1010. Acid. Albumen present. R. B. C's + Pus Cells ++. Treatment: Quinine grains 40.	
11-3-43.	Som e nausea. Says "feel not too bad". Is taking light diet quite well. Vomited once this morning. No other complaints. Treatment: Quinine grains 30 per day from now onwards; also mist.pot cit. & sode.bic. Fluids +++.	
12-3-43	Slept well. Not complaining.	
13-3-43 P.M.	Was sleeping during the morning round. This evening says that he was wakened at 4:00 A.M. this morning with a sudden pain in his right iliac fossa & has had pains of a cramping nature nearly all day. Pains spread across to the left iliac fossa. Vomited once today. Bowels opened once to-day (loose).	

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DATE	SIGNS of DISEASE & TREATMENT.	REMARKS
13-3-43 P.M. Cont.	On Examination: Appears rather flushed. Temperature 102.6. Pulse Rate 100. Lies with legs extended. Tongue is dry. Abdomen: There is much tenderness on light pressure over the right iliac fossa & also considerable tenderness over the rest of the abdomen. There is no rigidity but there is some resistance to Pressure (musels guarding). A Surgeon was asked to see the patient and decided that the Patient should be kept under close observation before any further action should be taken. (N.B.: It was decided that, although there was nothing in the Patient's clinical history to suggest that he had typhoid, a perforation had to be considered.) Treatment: Hotwater bottle. Fluids. Soludagenam 1 gram intra-muscularly at 9:00 P. M.	
14-3-43 8:00 A.M.	Temperature 97. Pulse rate 144. Patient states that he feels better. He slept for short intervals during the night. Has had no further vomiting and no further stools. The pain is less. On Examination: The tongue is slightly more moist. Pulse rate very feeble. Abdomen still rather distended. Examination much the same as yesterday evening.	
9:00 A.M.	White Blood Cells - 13, 400. Polymorphs 90%. Lymphocytes 8%. Monocytes 2%.	
10:15 A.M.	He was taken to the Operating Theatre & anaesthetic started.	
10:30 A.M.	Patient died without any operative proceedure having been performed.	

Post Mortem Examination.

The abdomen was opened and much yellow, cloudy, peritoneal fluid was seen. There was an adhesive peritonitis present in the region of the right, lower quadrant of the abdomen. Buried amongst the adhesions was a small perforation of the ilium near the ileo-caecal valve.

Conclusion: This Patient died from a perforated ulcer, due to typhoid fever. He had, in addition, Malaria, Benign Tertian.

Comment: The diagnosis of Malaria was made in Shamshuipo and there was no reason, whatsoever, to doubt this diagnosis, as his condition corresponded to that of Malaria. Apart from the rather loose stools, there were no physical signs of Typhoid Fever. The diagnosis is based on the fact that, if the fever was typhoid from the beginning, the perforation occurred at the beginning of the third week, a typical time for such ulcers to perforate.

(C. F. Harrison)
Major ----- R. A. M. C.
Medical Specialist.

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CASE NO	1297	NAME OF DIAGNOSING DOCTOR		G.C. Gray, Captain, R.C.A.M.C.	
UNIT	Winnipeg Grenadiers	NATIONALITY	Canadian	NAME AND RANK	STODGELL, Garnet. Age:- 26 years.
NAME OF DISEASE	Acute Enteritis.	DATE ADMITTED	2.3.1943.	~~DATE~~ DIED DISCHARGED	1. 20/3.

DATE	TREATMENT	REMARKS
2.3.43.		Admitted complaining of loss of appetite-occasional dizzy spells-slight cough & vomiting. On admission Chest and abddmen negative. T103.3
3.3.43.	Complete Bed Rest - fresh fluids. Aspirin. Light diet.	Vomited 5 times during night Blood film - no malarial parasites seen.
4.3.43.	Quinine gr.10. Light Diet plus extras.	Temperature rising again. Pulse 150 - no vomiting.
5.3.43.	Coramine 1.7 cc I.M.at 12 pm yesterday, again at 6 am to-day. Metabolin "Strong" 4 cc given IV at 10 pm.	Temperature 99.3. Pulse 150 Weaker and irregular. Vomited twice. Chest and Abdomen negative. Pulse dropped to 120 for about 2 hours.
6.3.43.	4cc Metabolin IV at 2 pm. 1.7 cc Coramine IM. Trianon 4cc IM, Digitalin 1/100th gr. Strychnine 1/60th gr. at 8 pm.	Pulse 160. Abdomen slightly tender. Hands cold and clammy. Respirations increased. Acute Cardiac collapse Collapsed at 4.30 pm. Passed 2 loose greenish foul smelling stools at 4.30 pm and 7 pm.
7.3.43.	Trianon 4cc IM. Diet - Milk,Eggs.	3 loose stools - Vomited 6 times.
8.3.43.	Digitalin 1/100th gr. at 4pm and 10 pm.	Pulse 150.
9.3.43.	Digitalin 1/100th gr. 4pm and 10pm. H.W.B. to Abdomen.	Very restless night.Pulse 140/150. Urinary frequency. Pain over bladder.
10.3.43.	Fluids.	T.normal-appears much better. P.135.
11.3.43.		Vomited again. Bile stained fluid.Abdomen negative on examination. P.130/140. Bed Sore over Sacrum has broken.
12.3.43.	Tinct.Benz Co and Castor Oil BID.	T.Normal.condition same.
14.3.43.	2 cc Metabolin IM daily for 6 days.	T.99.2.Appears brighter - no complaints.
15.3.43.		T.normal. Vomited again 7 during night. P.130.
16.3.43.		T.99.3.Spots appeared on Chest and Arms.
17.3.43.	Sodii.Bicarb. grs. 15.	T.normal.condition worse. Still vomiting most of food eaten. pm.-appeared quite confused-shouting.

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CASE NO	1297.	NAME OF DIAGNOSING DOCTOR	G.C. Gray, Captain. R.C.A.M.C.
UNIT	Winnipeg Grenadiers.	NATIONALITY	Canadian
NAME AND RANK	STODGELL, Garnet. Age 26 years.		
NAME OF DISEASE	Acute Interitis.	DATE ADMITTED	2.3.1943.
DATE DISCHARGED	1.15 am 20.3.1943.		

DATE	TREATMENT	REMARKS
18.3.43.		T.101. Became confused & noisy about noon. Quietened with Morphine Sulphate. Vomiting small amounts of bile stained fluids frequently. Now very emaciated. Taking less by mouth.
19.3.43.	1 amp. Cocaine.	T.98. Appeared a little better am. P.130. Weaker. Mid-day -another burst of confusion and shouting. Refused to take anything by mouth. Persuaded to take small sips of fluids later in evening - vomited. Difficulty in breathing 1am. DIED. 1.15 am. 20/3/1943.

Captain. R.C.A.M.C.

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Report on the Post Mortem Examination made at 10 a.m. on 20th. March, 1943, at Prisoners of War Camp, Shamshuipo, on the body of:- No.5748. Pte. G.J. Stodgell, Aged 26 years, Winnipeg Grenadiers, who died 1.15 a.m. on 20th. March, 1943.

- -

General Appearances.

The body was well developed but considerably emaciated. A diffuse haemorrhagic rash was present over the chest and upper arms. Rigor Mortis and Post Mortem Lividity were present. There were no wounds.

Head.

The cranium and its contents were healthy. A film of blood from a vein on the cerebral cortex failed to show the presence of malarial parasites.

Chest.

The pleurae were healthy except for a sero fibrinous pleurisy on the left diaphragmatic surface. The left lung was throughout much congested and nearly airless. The right lung and trachea were healthy. The pericardium and endocardium and coronary arteries were healthy. The myocardium was unduly brown but the heart was not dilated. The aorta showed early atheroma.

Abdomen.

The peritoneum was healthy. The liver was toxic and congested with bile. The gall bladder was greatly distended measuring 6" long but there was no obstruction to its outflow. The pancreas was healthy. The stomach was large and showed sub-mucous haemorrhages. The whole of the small intestine was acutely inflamed with swelling of the solitary lymph follicles but not of the Peyer's patches. The mesenteric glands were greatly enlarged. The appendix was acutely inflamed, the distal third being distended with jelly like material. The large intestine was healthy. The spleen was slightly enlarged (5" x 4" x 2") and moderately firm. A film of its pulp failed to show the presence of malarial parasites. Both kidneys were healthy except for acute toxic changes.

Summary.

I am of the opinion that death was due to:-

ACUTE ENTERITIS.

J. D. Allan Gray

Major, R.A.M.C.

Shamshuipo.
20th. March, 1943.

Distribution:- See reverse.

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E8000

Distribution:-

Japanese Medical Authorities.
Senior Medical Officer.
Capt. G.C.Gray, R.C.A.M.C.
File.

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Nº 1150 SNR. TURLAND.

No 26

COURS of DISEASE & TREATMENT.	REMARK.
27.1.43. Developed profuse pustular eruption of head hands. By Hand baths b.d followed by Cond dressings.	
30.1.43. Improving. Placed on nicotinic acid daily.	
6.2.43. Very depressed. ? to great stiffness of limbs and trunk. Skin now dry and scaly except for the shoulders which still show moist lesions. Peripheral nerves:- Sensation to pin prick dulled in limbs, except for feet: Knee jerks and ankle jerks present.	
10.2.43 Completed course of nicotinic acid today. By Thiamine chloride 20 mgm twice weekly. Wt 105 lb	
20.2.43. Skin has improved but still shows widespread lesions Appetite poor. Apathetic and has to be fed. Has mucoid corneal ulcer. By Atropine drops daily.	
23.2.43. No change. Weight now 91 3/4 lb	
27.2.43 Mind rambling. General condition unchanged. By Nicotinic acid.	
2.3.43 Incontinence of urine & faeces. Muco-purulent expectoration. Rales & crepitations over both lungs. T. 100. ? urine expelled and nicotine	
4.3.43 Pyrexia up to 101.4. Given intra-muscular salvedigman & placed on Tiranon by mouth. Incontinence continues.	
9.3.43 Improving. less incontinence. T & R normal for past few days; pulse around 100. Appetite improving. Trace of albumen in urine Discontinue Tiranon.	
17.3.43 - Improvement maintained. appetite returning. Sleeping better. No cough. no incontinence, but had diarrhoea. Mentally brighter. Bed sore over sacrum	
20.3.43. ? to Constriction feeling around chest. By Nicotinic acid daily.	
24.3.43. Evening pyrexia up to 100° again. Urine clear of albumen. By mistake	
27.3.43 Dribbles legs & thighs to pin prick. Skin still dry and scaling. Bed sore healing. No pyrexia past 2 days.	
31.3.43 By Heart Tablets & III daily.	
15.4.43 - Appeared to be improving daily. Appetite better. More cheerful. No cough. No pyrexia. Mucoid diarrhoea yesterday, none today. Asked for bed-pan at 2.45 PM today, passed solid stool. Collapsed while on bed-pan. Foot of bed raised, hot-water applied. By Coramine 1 c.c. No response. Died at 9.30 PM.	

P.M. Both lungs pale and airless, solid at right base. Calcified glands over right hilum. Patchy pleural effusion & pleural adhesions. Heart small. Thick white cord in ? endocardium in upper auricle; valves & rest of endocardium healthy. Small intestine very thin and atrophic.

Cause of death:- Pellagra complicated by pneumonia and endocarditis.

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No 27

ADMISSION NO. 962 NAME of DOCTOR maj. J. E. Swyer RAMC
Major J. Durran IMS

UNIT. R. E. NATIONALITY. British RANK. W. O. II NAME. BRANNON, O.

NAME of DISEASE. Chronic Colitis. DYSENTERY AMOEBIC Beri-Beri remote MITRAL INCOMPETENCE DATE of ADMISSION 28-10-42 DISCHARGE. DIED 4/5/43.

DATE.	COURSE of DISEASE & TREATMENT.		REMARK
Oct 28	Chronic diarrhoea, since before hostilities Ulcer has been treated for Amoebic Dysentery. Acute exacerbation last 2 weeks, now recovering. Anaemic Vitamin fed Thiamin 10 mg daily	Bed	Rest (3) Convalescent
29.	Bed 1.		
30	" 1		
31	" 0		
Nov 1.	" 3		
2	" 3		
3	" 2	Kaolin Zeo x 3	
4	" 5	Enterosuspine tabl. + enema	
5	" 4		
6	" 3		
7	" 1		
8	" 1		
9	" 0		
10	" 1		
11	" 1		
12	" 0		
13	" 1		
14	" 1		
15	" 0 Bowels normal. Last fæces voided on Pulse 92	Stool (10 days chart)	
16	" 96		
17	" 96		
20	Bowels normal. Fæces examined Pulse regular.		
30	"		Up.
Dec. 4.	Pile.		
11.		Beri Beri comm cit pastilles x 3	
10	Pulse 90.		
23	Bowels normal. Still some pain in feet. Still on beri beri comm cit. transferred to ward 3. Jan Brannon Major IMS		
26. 1. 43.	Still has oedema of feet: blood picture normal. B.O.R. Weight = 153 lb.		
14. 2. 43	Confined to bed for past 4 days owing to increased oedema of leg, face + hands and ankles. Heart: N.B diffuse, soft blowing murmur replacing the 1st sound.		

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980008

G.M.S BRANNON.

COURS of DISEASE & TREATMENT.	REMARK.
16.2.43 – Oedema +. Wt = 157½ lb. Rx Tinct. digitalis m x t.d.s.	
23.2.43 – Much improved. Wt = 149½ lb due to loss of oedema	
2.3.43:- Stool contained mucus +; laboratory reports presence of cysts of Entamoeba histolytica. Placed on emetine injection gr ¼ daily	
9.3.43 – Pulse deteriorating, attacks of dyspnoea increasing with gaseous distension of bowel.	
15.3.43 Pulse a little better. Ascites +. Urine scanty. diminished. Rx Thiamine 10 mgm daily intramuscularly.	
23.3.43 Looks & feels better. Pulse 90–100. Wt 159 lb (oedema)	
25.3.43. Still frequent stools with flatulence. Rx Enteric-vioform enema daily	
30.3.43. Rx Enteric-vioform tablets. General condition unchanged	
3.4.43 Increasing oedema of face. Cough with blood-stained sputum, which is negative for T.B. Hrs complete course of enteric-vioform	
5.4.43 X ray screening shows opacity right middle & lower lung zone. Continue Tinct Digitalis: Rx Thiamine ¼ III daily	
14.4.43 Delirious last night. Dyspnoeic. Dullness back bases. Blowing murmur replacing 1st sound in mitral area. Gaseous distension of abdomen	
20.4.43 Pleural effusion diminished. Cough troublesome. Pulse weak. Vomiting. Hrs required examine.	
21.4.43 Sputum negative for T.B.- predominant organism gram+ve diplococcus, resembling pneumococcus. Gaseous distension of abdomen, partly relieved by enema & pituitrin injection. Mentally confused.	
1.5.43. General condition slowly deteriorating. Sudden pain in right arm, followed by oedema, probably due to embolus. Sputum blood-red.	
3.5.43 Heart-failing. Oedema of back. Incontinence of faeces.	
4.5.43 Collapsed and died at 6.40 P.M.	

Post-mortem examination on 5.5.43:-

Heart- dilated, mitral valve incompetent. Ante-mortem clot in left ventricle. Pericardial adhesions present.

Pleural effusion. Congestion of lower lobe of lungs with infarction in right lower lobe. Adhesions at right base.

Kidneys, liver, adrenal & diaphragm. Kidneys and spleen normal.

Thin friable area in descending colon.

Appearances consistent with death from heart-failure, following pneumonia and accelerated by multiple infarction.

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No.28

Age.... 22 years.

CASE No. 247

ARMY No.	20456	NAME OF DIAGNOSING DOCTOR.		PARKASH SINGH SANGHA, JEMADAR, I.M.D	
UNIT.	5/7th. Rajput Regiment	NATIONALITY.	RANK AND NAME	Sepoy	KACHEROO SINGH
NAME OF DISEASE	BRONCHO-PNEUMONIA.	INDIAN.			
		DATE OF ADMISSION.	1/5/43	DATE OF DISCHARGE	DIED ON 7/5/1943, at 4.20 P.M.

DATE	TREATMENT.	Remarks
1/5/43.	Complains of diminished appetite, pain in the chest and cough Duration:- 15 days. Temperature- 99.6 F. Pulse.....- 76 per minute. Lungs.....- A few occassional rhonchi all over the chest. Tongue.....- coated. Throat.....- Congested. Knee jerks.- Normal. Bowels.....- regular. Liver.....- Not palpable. Spleen.....- hard and enlarged Heart.....- sounds feeble in all the areas. Blood for Malaria parasite- negative. Stools- Ova of ROUND WORMS seen. Sputum- No T.B. seen.	
2/5/43.	Blood for M.P.- negative. Sputum for T.B. negative.	
4/5/43.	Patient passed two ROUND-WORMS in stools	
5/5/43.	Patient complains of difficulty in breathing, troublesome cough with trace of blood in sputum. Temperature.... 102 F. Pulse 120, Respiration 36 per minute. Sibilant rhonchi all over the chest. Crepitation in the intra-scapular regions and bases of both lungs. Sputum for T.B. negative. Blood for M.P. negative.	
6/5/43. 8A.M.	No change in general condition. Patient did not sleep well last night. Now patient is little delerious. and the abdomen is slightly distended.	
4 P.M.	Distension of the abdomen relieved. Temperature 103 F. Pulse rapid and feeble. No improvement in other conditions.	
7/5/43.	Patient looks more toxic. Cyanosis has appeared on the face and nails. Alinasi are working- inverted respiration. Patient is in a state of low muttering delerium. Pulse 136, Respiration 44 per munite.	
4 P.M.	Patient has gone from bad to worse. Has passed into a state of stuper, passes loose bilestained motions involuntarily. Conjuntival reflex is sluggish. Pulse imperceptible at the wrist. Futures are pinched, Respiration quick and laboured.	
4.20PM.	Patient EXPIRED at 4.20 P.M.	

JEMADAR, I.M.D.
COMMANDING DAI NI BUNKEN, SHO.

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No. 29

Major J. [illegible], R.A.M.C.

ADMISSION No. 1007 NAME of DOCTOR Major G. [illegible], R.A.M.C.

UNIT. H.K.V.D.C. NATIONALITY British RANK NAME. Private Brown, J.

NAME of DISEASE. Pulmonary Tuberculosis DATE of ADMISSION 8-11-42 DISCHARGE.

DATE.	COURSE of DISEASE & TREATMENT	REMARKS
1-[illegible]	P.F.H.: Diarrhoea since January, 1942.	
	O. A.: General oedema 6 weeks; numbness of feet for 4 weeks. Knee jerks, ankle jerks present. Tendon reflexes. Diminished pinprick. Temperature 101°.	
	Blood Slide for Malaria - negative. Thiamin Chloride 10 mgms daily.	
11-11-42	Stool contains cysts of E.histolytica. Emetine gramins 1 daily.	
13-11-42	Total 6 grains Emetine.	
18-11-42	Diarrhoea still present. Incontinent. Bismuth Salicylate. Tinct.opii.	
25-11-42	Bowels much improved. Enterviofom enema daily. Tinct.opii.	
3-12-42	Bowels opened 5. Improving.	
7-12-42	Stop Tinct.opii.	
11-12-42	Trimon 1 grain 3 times per day.	
5-1-43	C.F.O. much better. Stop trimon.	
1-1-43	Bowel movements normal. Increasing weight.	
3-1-43	Full diet.	
5-1-43	Sitting up.	
9-1-43	Up for 15 minutes.	
11-1-43	Up two hours. Walking to annex.	
14-1-43	Still improving.	
15-1-43	Diarrhoea. Castor Oil. Bismuth grains 30 3 times per day.	
21-1-43	Stop bismuth.	
3-2-43	Had a cold.	
13-2-43	Complications left lower lobe.	
24-3-43	Course: Collapse upper lobe; pleural complications; no guinea pig to pulmonary tuberculosis.	
1-3-43	X-Ray corroborates clinical findings.	
13-3-43	Tuberculin fluid. (TUBERCLE BACILLI Griffin No 5)	
	Case transferred to K.G.V. Hosp.	

(J. [illegible])
Major R.A.M.C. H.K.V.D.C.

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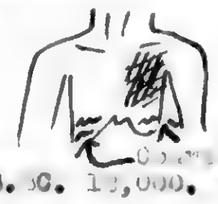
Page 1 Pte [illegible]

DATE.	COURS of DISEASE & TREATMENT.	REMARK
19-3-43	Complains of cough for 7 days. No pain in the chest. X-Ray shows infiltration in upper half of left lobe with cavity formation. O. E.: Thin and emaciated. General condition very poor. Lungs: - Left side chest moves poorly; muscles breathing under left clavicle. Crepitations (coarse) plus plus.	
3-4-43	Complains of tightness across chest. Treatment: In order to preclude malaria, quinine grains 30 p.d.	
5-4-43	Still running persistent temperature. Stop quinine. Try Tryparsamide .6 gram for 5 days.	
10-4-43	Complains of pain in the right side, which is now more severe. Also has difficulty in breathing. Strap applied to lower chest with success.	
20-4-43	Trinon 4 grams to-day. Urine: Nil abnormal found. W.B.C. 8,600. Polymorphs 88%; Lymphocytes 12%. Is not producing much sputum. Appears cheerful. Tongue, dry & red. Motions are loose. Is on milk, eggs & all available extras.	
3-4-43	Has had 39 grams of Trinon. Temperature was depressed at first but has now returned to its former level.	
5-4-43	 	
7-4-43	Very cheerful. B. P. 105/50.  Coarse friction fremitus. W. B. C. 13,000. Polymorphs 83%; Lymphocytes 17%; Eosinophils 1%.	
10-4-43	In view of previous history of amoebic dysentery, he was given 7 1/3 grains of emetine-hydrochloride as a precautionary measure between 5-4-43 and 11-4-43. This had no effect on his temperature.	
17-4-43	Very much brighter. Says feels well but is anxious. Physical signs as before. Stools are still rather loose.	
20-4-43	Has had 10 grams.	
1-5-43	Normal temperature. Continues until 10th.	
4-5-43	X-Ray shows: 	
6-5-43	Sputum nil. Has had 50 grams. Temperature has remained for 3 days out of last 10 days.	
10-5-43	General condition & temperature. No sputum. No pus bacilli. Has had total 60 grams.	
14-5-43	Very poorly ill. Chest practically same. Stopped trypar.	
17-5-43	Complains severe pain in chest. Has had 70 grams. W. 5:00 P. M. Patient died.	

Medical Officer

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DATE.	COURS of DISEASE & TREATMENT.	REMARKS.
	Result of Post Mortem Examination of the body of the late Private Brown, [illegible] J.? H. K. V. D. C.	
	Twin, united body.	
	There was some degree of oedema of the tissues generally.	
	The left lung was practically solid with a tuberculous, bronchopneumonia. In the upper third, there was a large cavity with grumous matter inside. The right lung was extensively involved with tuberculous lesions.	
	Nothing of any note in remaining organs.	

(W. F. Harrison)
Major --- R. A. M. C.
Medical Specialist

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16808

No.30

ADMISSION NO. 1266 NAME of DOCTOR

UNIT. A.I.F.D.C. NATIONALITY RANK NAME.

NAME of DISEASE. { Beri Beri / Carcinoma of Prostate gland.(R) DATE of ADMISSION 13-4-43 / DISCHARGE died 14.5.43

DATE.	COURSE of DISEASE & TREATMENT	REMARKS

W.W. Vanner

(

)

James Callender

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No. 31

ADMISSION No. 1032. NAME of DOCTOR Major J. Dunnan. RAMC.

UNIT. Winnipeg Gren. NATIONALITY. Canadian. RANK & NAME. Private. [illegible]

NAME of DISEASE. Avitaminosis. 'B'. DATE of ADMISSION 18.1.1943. DISCHARGE. 26.5.1943. (DIED).

DATE	COURSE of DISEASE & TREATMENT	REMARKS
Dec.18.	History unobtainable. Confusional mental state on admission. Three months history of sore feet. Bed sores. Semi-blind. Deaf. Treatment :- Thiamine. 10 mgms. daily. Morphia. gms. 1/4. Hyoscine. gms. 1/100 Nocte.	BED. Died 2.
" 19.	B.I.D.	-do-
" 20.	B.O.I. Mental state: I.D.D. Noisy at night.. Hallucinations.	-do-
" 21.	B.O.I. Incontinence of urine and faeces. Hallucinations. Restless. Treatment :- Chloral [illegible] Bromide. ... 10 ccs x 4.	
" 22.	Pulse. 150. Improved. Mental state clearer. Appetite good. Treatment :- ... 7 c.c. ccs.x 4.	
" 23.	Sleeping [illegible].	Treatment :- [illegible]. gms. 1/4.
Jan. 1.	A little [illegible].	
" 7.	[illegible]	
" 15.		Cocaine. 1 mgm. daily.
" 27.	[illegible]	
" 30th.	I.D.D.	Cocaine 1 mgm. x 2.
Feb. 3.	[illegible]. Discs very pale. [illegible]	[illegible] 1 mgm. x 2.
Feb. 10.	[illegible], feeding [illegible], in bed.	Hospital bed. [illegible] ccs.
Feb. 5.		Air ring. [illegible] cc.
Feb. 6.		[illegible] Cocaine and Bromide.
Feb. 7.	[illegible] Bed [illegible] [illegible] - I.D.D. Pulse.	
Feb. 10.	[illegible]	[illegible]
Feb. 20.		Cod liver oil. Cocaine. 1 [illegible] x 2. [illegible] 1 mgm. daily. B. [illegible] 1/2 times 1. Yeast [illegible].
Feb. 21.	[illegible]	

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M E D I C A L C A S E S H E E T

No. 32

	CAMP NO	RANK	NAME	UNIT
	164	Sgt.	MURRAY I. N.	

DISEASE 1. Post Diphtheria 2. Pericarditis (subacute) AGE
Pellagra polyneuritis 3. Chronic NEPHRITIS 42

DATE 11/2. 1500 bed 15th NOVEMBER.

Diphtheria March 4th following aching feet pellagra stomatitis
Never had a pellagra dermatitis. Feet even skin very easily
but feet very bad. Had 17 injections nicotinic acid. Developed
rheumatism with fever after 10th injection. Board of Constitution
across stomach No diphtheritic paralysis.
Aching feet now - burning. no cracks. Stomatitis still present
much improved. Vision - can read. Before he could not read
at all. Improvement due to injections

PD.
Bronchiectasis for July. (Empyocarditis).
Rheumatism Fr. 1902. Cleared up with Cod Saliey & Iodobromatin.
Never had rheumatic fever.

OE.
Heart. Diastole brief.
Joint sense OK. Vibrations.
Capt. Wallace 1 cm teeth. Teeth OK

11/2 Treatment. Milk. K. B. 1 dist. Mist Aspirin. tds.. Carbolism washed.
13/2. Bad night burning feet
14/2 Feet bad.
15/2. Bad feet last night with lightening pains for first time in 1 month. ? Pan. emptying himself
Yeast tabs.

Best wt. 162

15/2 Weight 111. lbs.
22/2. -- 112 lbs

16/2 Bad night. Lightening p... Codeine gr ½. nocte.
17/2. Poor sleep. Mist Aspirin. 3ss pm
18/2 Fairly good night.
19/2. Rheumatism bad. Sore throat. Mist Aspirin 3ss pm Pyramin 40 mgs pm
20/2 Better night.
22/2 Fair night pulse rapid. Mist Aspirin 3ss.
24/2. Good night
25/2. Stiff. Good sleep. Mist Aspirin. 3ss
26/2. Rheumatism
27/2. Rheumatism worse.
Recommended for transfer to Convalescent Depot.
Bad night.
3/3. Good night. Skin breaking Left

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Sheet 2.

5252 MURRAY LN. Sgp. HK&OC.

	COURS of DISEASE & TREATMENT.	REMARK
Mar. 5.	Admitted Emaciation considerable Heart: Tachycardia. 1st Sound poor. 2nd sound sharp Mental state: very nervous & emotional. Nervous System: Muscle tones poor & lax Calves tender. + Dupuytren's Contraction Hyperaesthesia legs - to feel. No anaesthesia. Burning feet. Shooting pains. Urine. Nil abnormal.	
7.	Rheumatic pains.	Mepacrine 40 mg t.i.d. Mist. Pot. Sol. 4 hrly. mag Sulph. 3 xxx daily.
10.	Constipated.	
12.	Runs slight temperature Blood Count. Total. white. 11,900. Polymorph. 68%.	
26		Mist Pot. Sol. 4 hrly.
28	Still temperature.	Lucil. 1 gm x 3. Nicotinic Acid 10 mg x 2.
Apr. 4.	Temperature effect on temperature only.	Mist Lucil Total 45 gm.
8.	Temperature still remaining. Mouth. No melaena.	Quinine 3 v x 4.
11		Mist Quinine. Total 100 grains.
20		Mist Nicotinic Acid. (Total 3410 mg.)
		B_2 Tablets ½ x 8.
30	General oedema	Mepacrine 50 mg.
May 1		
3.	Urine contains ten times ½ volume Oedema increasing.	Mist. Urea.
4.	Chest Pain in precordial area → L. Shoulder. Friction over cardiac area Dullness over left pulmonary area. X. Ray reported. Heart shadow normal. Fluid in pleural cavity (moderate amount) Mouth Blood Count: W.B.C. 18,200 Polymorphs 80%.	

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Sheet (2)

MURRAY LN. Sgt.

	COURS of DISEASE & TREATMENT.	REMARK.
May 8.	Urine Albumen. 25 g. Blood 72 g.	
9.	General Condition poor. Dyspnoea Heart shows signs of failing.	
10		Coramine. inj 2.c.c.
11.	Better this a.m. Can lie flat. Stricture still present.	Adj Coramine. (Total 5 amps)
18.	X. Ray Chest. Heart shadow widened — pericardial fluid Fluid level in pleural sac r. base.	
19		Digoxin Tab 6. Digoxin Tab 2.
		Adj B.P. Tab. (Total 45 Tab)
22.	Oedema decreasing Very weak Pulse.	
28	Unsatisfactory. Oedema increasing again Heart failing.	Adj Digoxin Total 25 Tab.
30.	Temperature To Mortuary.	
31.	Pulseless. Very WEAK. ON EXAMINATION Thin, wasted, white. OEDEMA of Legs & Abdomen. Lungs L. Base — Some dullness on percussion. Diminished Vocal Resonance. Harsh Vesicular breathing. Impulse not appreciable. Irregular Rhythm Heart to Apex Beat. B.P. = 150/125. (Gives history of Pulmonary Oedema some months ago)	
June 1.	Poor night. Very little Sleep in spite of Pot Brom + Chloral hydrate. Treatment Digitalis gr 1/100 tab. & Ammonium Chloride gr 60 per Rectum. General Condition very poor. Cheyne-Stokes Respiration started in morning. Temp 101.5. Albumin No Pathological Casts. Deposit :- Triple phosphate only. Patient died at 2.20 p.m.	

Results of Post-Mortem Examination :- Thin, wasted body. Marked oedema. Pleural cavities contained fluid. Pericardium - Red, congested, inflamed. Pericardial fluid slight excess. Cloudy (purulent). Fibrinous deposit present on surface of heart & on internal surface of pericardium. Heart very large. Weight = 19½ oz. Thick left Ventricle Valves normal. Aortic Patency. Appearance of Chronic Congestion. Kidneys : Capsules Stripped. Surfaces. Disorganised pyramids. Evidence of Chronic Nephritis. Spleen 2 oz. Lungs Congested.

Conclusion :- Patient suffering from Chronic Nephritis & died from the effects of Subacute Pericarditis with heart failure.

Major RAMC

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NO. 33

入院番号 Admission Number	136.	診断軍医名 Name of Doctor	MAJOR J.W. ANDERSON RAMC
収容部隊名 Unit	Royal Navy	国籍 Nationality	British
病名 Name of Disease	COMPOUND FRACTURE SKULL CEREBRAL	入院日 Date of Admission	18-1-42
階級氏名 Rank & Name	L/S. R.E. Halfyard
退院日 Date of Discharge	2-6-43

月日 Date	治療 Treatment	後送区分	摘要 Remark
18/1/42	Admitted from Royal Naval Hospital Chatham where a subtemporal decompression on L/S side had been done for tremor symptoms following compound fracture of the skull. He had been maniacal & confined in a straight jacket. Pus was evacuated from subtemporal area on 7/1 & on 9/1 pus was "found in brain."	Stretcher.	
23/3	X-ray: decompression L. lower parietal area: G.S.W. post. part sagittal suture. Between these two areas there are several small sequestra.		
8/6/42	Sequestra extruded at intervals from post. scar.		
15/6/42	Attacks of numbness of arm & chest yesterday.		
17/6/42	C/O headaches after being on parade.		
	Numbness & fit: clonic spasms. No Coarsening of eyes or limbs. Had to be restrained & fought powerfully. Unconscious.		
	Back 2 days.		
9/7	Another attack - numbness R. arm.		
12/8	Has remained free of further symptoms: feels well.		
12-9-42	Another attack similar to last.		
	Mist. 2/15 + d.s. Morphia gr 1/4.		

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HALF-YARD. Page 2.

DATE.	COURS of DISEASE & TREATMENT		REMARK
12·10·62	Further attack		
20·11·62	Continuous headache last 2 weeks. Under care Lond. Running fever.		
21·11·62	Operation: Local anaesthetic. Brain explored & cerebral abscess found 3½" from surface. Drained. Improved after recovery from this.		
28·3·62	Headache behind eyes. Restlessness. Pain L. side of head. Morphia gr ¼		
30·3·62	Convulsion similar to last. Morphia gr ¼		
4·5·63	Bone swelling L side (for decompression)		
6·5·63	Severe headache - disordered movements. Headache continuing.		
21·5·63	Operation: Morphia gr ⅓. Local + ether (light) Incision along previous scar. Opening in bone enlarged by nibbling forceps. Pus & 3 F.B.S. (bone sequestra) found medial to incision & within 1" of mid-line at depths up to 3½" from surface. Necrotic brain tissue removed. ¾" tube inserted. Daily secretion of pus which became foul smelling after a few days. General condition improved after operation & more nourishment taken by some days. Patient developed K. ammonia.		

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DATE.	COURS of DISEASE & TREATMENT		REMARK
1.6.43	Secondary haemorrhage from incision of brain – large piece of necrotic brain tissue extruded. Hernia cerebri in decompression opening. Bleeding controlled by tubeing & packing towards evening. General condition then rapidly worsened temperature, pulse respiration rising.		
2.6.43	Following 24 hours unconsciousness death took place 1.50 p.m.		

James Anderson
Surgn
R.N.V.R.

此處收一件

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08/08

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CLINICAL CHART

3.

UNIT _____ RANK & NAME HALEYARD L/S. AGE ____ DIAGNOSIS _____

DATE OF ADMISSION _____ DATE OF DISCHARGE _____

DATE DEC 10 11 12 13 14 15 16 17 18 19 20 21

TEMPERATURE: 170 160 150 140 134 130 120 110 100 90 80 70 60 50 40 30

PULSE: 170 160 150 140 134 130 120 110 100 90 80 70 60 50 40 30

RESPIRATIONS: 50 45 40 35 30 25 20 15 10

0% D.L.

BOWELS

SIGNATURE OF DOCTOR

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No. 3

CASE NO		NAME OF DIAGNOSING DOCTOR	Major J.U.B. Crawford, R.C.A.M.C.		
UNIT	nnipeg enadiers	NATIONALITY	Canadian	NAME AND RANK	4894. Pte. Johnson, David.
NAME OF DISEASE	Uraemia.	DATE ADMITTED	6.6.43.	DISCHARGED	Died 7.6.43.

Age:- 51 years.

DATE	TREATMENT	REMARKS
6.6.43.	Admitted Hospital with 1. Mental Confusion. 2. Delirium.	Has had 3 severe attacks of clinical dysentery. For past 6 months has been complaining of defective vision and sore feet. These were thought to be evidence of a vitamin deficiency. Had been receiving regular injections of Thiamine. Looks old for his years. Hair Grey. Arcus Senilis well marked. Orientation poor. Co-operation poor. Nasal and Throat - N.A.D. Lungs clear Reflexes - All deep tendon reflexes sluggish. Heart -Rate 82-pulse full Provisional diagnosis - Pellagra Dementia. No evidence of Valvular disease. Abdomen N.A.D. Mental confusion worse. There is a suspicion of a mass in right upper abdomen. Noon - no urine passed since admissio Mental confusion has deepened into coma. Diagnosis - Uraemia .
6.6.43.	Nicotinic Acid by injection. 50 mgms daily. Diet - Extras.	
7.6.43.	Force fluids by mouth. 250 cc glucose in saline intravenously. 8 pm. Patient died in coma wibhout regaining consciousness.	

J.U.B. Crawford,
Major, R.C.A.M.C.

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REPORT ON THE POST MORTEM EXAMINATION MADE AT SHAMSHUIPO PRISONERS OF WAR CAMP AT 9.30 AM. ON 8TH JUNE, 1943 ON THE BODY OF:- POW No.4894 PTE JOHNSTON, DAVID. WINNIPEG GRENADIERS, AGED 51 YEARS WHO DIED AT 8 PM ON 7TH JUNE, 1943.

General Appearances

The body was well developed and well nourished. There was post mortem lividity but no rigor mortis. There were no signs of violence. There was a slight icterus throughout the body.

Chest

The pleurae, lungs and trachea were all healthy except for slight oedema of the lungs. The pericardium and endocardium were healthy but the myocardium showed marked degeneration and considerable dilatation. There was early atheroma but no obstruction of the coronary arteries. The aorta showed no evidence of syphilis and practically no atheroma.

Abdomen

The peritoneum, liver, gall bladder, bile ducts, pancreas, spleen and urinary bladder were all healthy. The stomach was large but otherwise healthy. The intestines were healthy but the whole of the large intestine was overloaded. Both kidneys showed the sub-acute stage of glomerulo-nephritis. The macroscopic changes in the kidney vessels seen in nephro-sclerosis were entirely absent.

Head

The occipital bone showed an area of callus $\frac{5}{4}$" in diameter due to an old injury. The underlying duramater was firmly adherent to the callus. Apart from oedema of the brain, the brain and blood vessels were healthy.

Summary

I am of the opinion that death was due to:-

1. Uraemia.
2. Sub-acute glomerulo nephritis.

J. N. Allan-Gray

Major, R.A.M.C.

Shamshuipo.
8th. June, 1943.

Distribution:-

Japanese Military Authorities.	1.
Senior Medical Officer.	1.
Major J.N.B. Crawford, RCAMC.	1.
File.	1.

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CASE NO		NAME OF DIAGNOSING DOCTOR		Lieut. A.M. Rodrigues, H.K.V.D.C.			
UNIT	H.K.V.D.C.	NATIONALITY	Portuguese.	NAME AND RANK	Pte. BARROS. Luiz. Age:- 31 years.		
NAME OF DISEASE	1. Acute Hepatic Obstruction. 2. Malignant Malaria.		DATE ADMITTED	15.8.43.	DATE DISCHARGED	1 a.m. 23.8.43.	

DATE.	TREATMENT	REMARKS
15.8.43.	Feverx and Headache on admission. No history of malaria or dysentery. Quinine and Aspirin Grs x twice daily.	Fluid Diet. Tep. 102 F. pm.
16.8.43.	Aspirin grains 10 b.d. Injection Quinine 10 gr. p.m. Vomiting 2 pm - nothing retained. One live round worm passed in vomit. Enema and Hot sponge with little lowering of fever.	Temp. 102 F. a.m. Tongue clean. xxxx Spleen not palpable. Blood examination negative.
17.8.43.	Quinine injections continued. Still vomiting. Another round worm vomited . Morphine gr. 1/4 gave good sleep.	Temp 102 F. a.m. 100 F p.m.
18.8.43.	Kept on fluids. Tea vomited in the morning but milk and soup retained.	Temp 99.4. F. Feels better but still nasea . Pulse good.
19.8.43.	Quinine gr. 10 b.d. intramuscular. Calomel given but vomited.	Temp 99 F. a.m.
20.8.43.	Trianon given hourly for 4 injections. 0.2. mgms each injection. Epistaxis profuse.	Blood examination. Negative to Malaria White cells 20,900 Polys 89. Monos 7. Lymph. 4.
21.8.43.	Vomited blood and 1 dead round worm. Feeding by rectum. Eggs and Milk. Sodii Bic gr. 10 in 4 ozs of Water, by syringe. Morphine grs 1/6 at night.	Had some sleep but delirious in the morning. Pulse 120, but breathing 40.
22.8.43.	Blood taken again. Malignant Tertian Crescents seen. Patients jaundiced and unconscious. Cold Water enema and cold sponge brought fever down to 100 F but rose again towards the evening. 105 F at 10 p.m. Quinine grs 10 being continued intramuscularly. Patient comatosed. Breathing rapid.	Temp. 105.6. F.
23.8.43.	Passed away 1.00 a.m.	

Lieutenant, H.K.V.D.C.

Lieut Colonel
major Inf.
Legal medical officer.
23/8/43.

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REPORT ON THE POST MORTEM EXAMINATION MADE AT 10 A.M. ON THE 23RD AUGUST, 1943 AT SHAMSHUIPO PRISONERS OF WAR CAMP ON THE BODY OF NO. 601. PTE. BARROS, LUIZ, H.K.V.D.C., AGE 31 YEARS WHO DIED AT 1 A.M. ON 23RD AUGUST, 1943.

General Appearances

The body was well developed and well nourished. There were post mortem lividity, rigor mortis and jaundice. There was an old, well healed vertical scar 3" long in the right paramedian abdominal line. There were no wounds.

Chest

There was a terminal patch of pleurisy over the right apex. Both lungs showed congestion and oedema. The heart showed a patch of sub-pericardial haemorrhages underlying which was a marked atheromatous narrowing of the descending branch of the right coronary artery. Both coronary arteries showed advanced atheroma but there was comparatively little atheroma in the aorta.

Abdomen

There was no free fluid in the peritoneal cavity. Old adhesions were found round the gall bladder, the bile ducts, the head of the pancreas and caudate lobe of the liver. The common bile duct was occluded by fibrosis from the junction of the hepatic and cystic ducts distally for 1 cm. No foreign body was found. The liver was pale and not enlarged and showed no evidence of clonorchis infestation. The intestines were healthy and no round worm was found. The appendix had been removed. The spleen measured 5" x 4½" x 2" and was typical of chronic malaria. The kidneys and bladder were healthy.

The cranium and its contents were healthy. There was no atheroma of the arteries.

Summary

I am of the opinion that death was due to:-

1. Malignant Malaria.
2. Biliary obstruction .
3. Coronary occlusion.

J. D. Allan Gray

Shamshuipo.
23rd August, 1943.

Major, R.A.M.C.

Distribution:-

1. Japanese Medical Authorities.
2. S.M.O.
3. Lieutenant Rodrigues.
4. File.

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CASE NO		NAME OF DIAGNOSING DOCTOR		Capt. A.H.R. Coombes, R.A.M.C.	
UNIT	Dockyard Defence Corps.	NATIONALITY	British	NAME AND RANK	Sgt. WOOD. Arthur Frank. Age:- 49 yrs.
NAME OF DISEASE	Malignant Malaria	DATE ADMITTED	17.8.43.	DATE [redacted]	25.8.43. 5.20 a.m.

DATE	TREATMENT	REMARKS
	17.8.43. Aspirin Gr. 10 b.d. Fluid Diet only. Cold Sponge if fever over 103 F.	Admitted with fever, headache and joint pains. General weak condition. Fever 102.8 F. Spleen not palpable. Blood negative for malarial parasites.
	19.8.43. Continue above treatment and diet.	Fever continued fever. Normal in the morning rising to about 103 F. p.m.
	20.8.43. Continue treatment with Aspirin.	Diarrhoea with watery brown stools. 3 or 4 times during day and night.
	22.8.43. Continue treatment (No quinine available)	Much weaker from repeated sweating and diarrhoea. Blood showed M.T. parasites in profusion.
	24.8.43. Cold sponge every hour. Vitacamphor 2 cc 10 p.m. Vitacamphor 2 cc intravenously at 5 a.m. (25.8.43)	Fever higher 1c04.6. in the evening. Very weak. rapid pulse. Later delirious. Very restless.
	25.8.43.	Became after 12 midnight. Later comatose and [redacted] died at 5.20 a.m.

A.H.R. Coombes,
Capt., RAMC.

Lieut-Colonel
Major R.A.M.C.
Senior Medical Officer
25/8/43.

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CASE NO		NAME OF DIAGNOSING DOCTOR	MAJOR L.W. ASHTON – ROSE R.A.M.C.		
UNIT	R.A.V.D.C.	NATIONALITY	French.	NAME AND RANK	Anr. Mallieu. Pierre E Age:- 30 yrs.
NAME OF DISEASE		DATE ADMITTED		DATE DISCHARGED	10.10 p 27.8.43

DATE	TREATMENT	REMARKS
27.8.43	ARTIFICIAL RESPIRATION INTRA CARDIAC ETHER " CAMPHOR IN OIL INTRA MUSCULAR STRYCHNINE	SUDDED ATTACK NO RESPONSE TO TREATMENT

Lewis Ashton Rose
Major R.A.M.C.
Senior medical officer
27. 8. 43

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CASE NO		NAME OF DIAGNOSING DOCTOR		Lieut. S.M. Bard, HKVDC.	
UNIT	H.K.V.D.C.	NATIONALITY	British	NAME AND RANK	Cpl. Stimpson, Cornelius Charles. Age:- 41 yrs.
NAME OF DISEASE	1. Avitaminosis. 2. Dysentery. 3. Chronic Diarrhoea. 4. Cardiac Failure.	DATE ADMITTED	11.6.43.	DATE Died.	1245 p.m. 27.8.43

DATE	TREATMENT	REMARKS
11.6.43.	Admitted to Hospital with history of diarrhoea on and off for several months	On examination - wt. 138 lbs. Patient Thin, Anaemic. No physical signs.
13.6.43.		Persistent diarrhoea 3-4/24 hours. Stool exam.1.
21.6.43.	Nicotinic Acid administered - total 2 gms. Ferrous Sulph. 6 gr.daily.	Increase in undigested fats - nil else.
1.7.43.	started.	No improvement.
27.7.43.		Extras to diet - milk, 1 egg daily.
2.8.43.		Stool exam. 2. Many catarrhal cells,undigested fats.
3.8.43.	Trianon Tabs. by mouth - total 3 grms.	Condition worse - Stool exam. 3. Many catarrhal cells-undigested fats.
7.8.43.	HCL dil 15 m. t.d.s.	No improvement. No ova or cysts.
8.8.43.	Liver injections. I.M.I. total 6 given.	Blood exam. Hb 45% RBC, 3,700,000.WBC.9700 Diff. count - normal.
9.8.43.	Emetine ⅛ gr H.I. daily. total 6 gr.	Condition deteriorating. No
17.8.43.	given.	improvement.
18.8.43.	Morphine HCL. by mouhh ⅛ gr t.d.s.	Blood count - HB 60% RBC 4,000,000. Diarrhoea still uncontrollable.
25.8.43.	In the evening condition suddenly turned worse. Pulse very weak and rapid. Diarrhoea very frequent. 11. p.m. 20 c.c. of 20% glucose given I.V.I. 2.c.c. Camphor in Oil I.V.I.	Patient growing weaker. Diarrhoea very frequent.
26.8.43.	Pulse Slightly better. 10 a.m. 1o a.m. 20 c.c. of 20% glucose IVI 11 a.m. 1 cc of Rodsalone IVI. 2 tabs. of Vit. C. t.d.s. - 6 tabs. 9 pm. 20 cc of 20% glucose IVI 1 cc Metabolin IVI. 10 pm. 1cc of Rodealone. H.I.	1 hourly feeds of Lacovo malt with milk. Warmth.
27.8.43.	3 am. Turn to Worse. Coramine 1 cc HI. Pulse thready. Coramine 1 cc HI. 3.30 a.m. 15 c.c. of 20% glucose. IVI. 5 cc. of 20% glucose HI. 2 cc of Camphor in oil I.V.I. 6.30 am. Condition much worse. 1 cc of Rodealone IVI. 7 am. patient is sinking rapidly. 9 am very slight improvement. 2cc camphor in oil. I.V.I. 11 a.m. 20 cc of 20% glucose IVI. 1cc Rodealone IVI. 11.30 a.m. Pulseless and incontinent. Patient moribund. 1245 pm. Patient died.	

[redacted],
[redacted],

Major, I.M.S.,
Senior Medical Officer.

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Admission No. 1357. Name of Doctor. Major J. Durran. R.A.M.C.

Unit. Winnipeg Grenadiers. Nationality. Canadian. Rank. Private.
Name. Boswell. E.A.

Diagnosis. CHRONIC COLITIS.

Admitted. 31.8.1943.
Discharged. 29.11.1943. (DIED).

Course of Disease and Treatment.

31.8.1943. Admitted Military Hospital, Bowen Road.
On admission - emaciated, mentally dull, tender left colon. C.N.S. Normal.

4.9.1943. Nausea. Vomiting. Temperature 102. Diarrhoea. No blood or mucus.

6.9.1943. Temperature normal. Nausea. Anorexia.

12.9.1943. B.O. 111. Lab Reports. Stools negative.

15.9.1943. Rigor. Vomiting.

20.9.1943. Vomiting.

26.9.1943. Bowels now regular.

10.10.1943. Pain and diarrhoea.

13.10.1943. Lab. Report. E. Histolytica. Transferred to Ward No. 8. EBI. grs 111. daily.

22.10.1943. Completed 10 days E.B.I.

23.10.1943. B.O. 5.

25.10.1943. B.O. 6. Alsalin 1 gr t.i.d.

27.10.1943. B.O. 9. Mucus. Vomiting. Stop Alsalin.
Acid Hydrochlor Dil.
minims 10 x 3 times.

1.11.1943. Both bases dull. Right side pleural fluid.

2.11.1943. B.N.O. Chest improved.

4.11.1943. B.O. 1. Right base still dull.

12.11.1943. B.O. 7. Chest a little better.

14.11.1943. B.O. 1. Condition poor. Chest - Bronchi both bases.

16.11.1943. Right chest worse. B.P. 85/55.

18.11.1943. B.O. 1. Chest a little clearer. Appetite good.

20.11.1943. Chest much the same.

23.11.1943. Signs of Bronchial Pneumonia both bases.

24.11.1943. Incontinent. Cough troublesome. Condition poor. Pulse 120.

25.11.1943. Chest I.S.Q. W.B.C. 4,200.

26.11.1943. Incontinent. Worse. B.P. 60/50.

27.11.1943. Temperature [illegible] 96. Pulse. 102. Respirations 36. Bronchial Pneumonia more widespread.

28.11.1943. Very low. Condition hopeless.

29.11.1943. Died at 8.45 a.m.

POST MORTEM :- Chronic Colitis. Liver and Spleen - Underweight. Heart - Normal. Both lungs extensive Bronchial Pneumonia. (Lungs immediate cause of death.)

Major H. K. V. D. C.

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CASE NO		NAME OF DIAGNOSING DOCTOR		Captain G.C. Gray, R.C.A.M.C.	
UNIT	Winnipeg Grenadiers.	NATIONALITY	Canadian.	NAME AND RANK	BADGER, George. Private. Age:- 21 years.
NAME OF DISEASE	Malaria B.T.	DATE ADMITTED	28.10.43.	DATE Died ~~XXXXXXXXX~~	5.30 p.m. 5.11.43.

DATE	TREATMENT	REMARKS
28.10.43.	Admitted. Headache. Generalised Abdominal aches, occasional shivers. Loss of Appetite - 3 days. Companions noticed **interic** tinge of sclera yesterday. Temperature on admission - 100 F. Bowels open No previous Malaria known. Sclera definitely icteric. Tenderness over whole abdomen, particularly over upper abdomen. Spleen felt with Finger. Tenderness in Epigastrium just below costal margin and to right of mid-line. Temperature 101.2 F. p.m. Blood film taken.	
29.10.43.	Temperature normal this .a.m. Blood Film - B.T. Malaria. Prescribed - Quinine grs v t.i.d. for 8 days. LIGHT DIET.	
30.10.43.	Temperature 100 F. p.m. Normal a.m. Pulse 80.	
31.10.43.	Temperature 99.2. p.m. Normal a.m.	
1.11.43.	Temperature - Normal p.m. and a.m.	
2.11.43.	P.M. 99.2.F. No bowel movement since admission. Occasionally vomiting. a.m. Temp. 98.2.F.	
3.11.43.	Temperature Normal. Prescribed - Mag. Sulph. stat and in a.m. Jaundice less.	
4.11.43.	Temperature normal. No bowel movement up till to-night. Prescribed - Soft Soap Enema - good result.	
5.11.43.	Temperature normal - patient appears much worse in last 24 hours. Jaundice has markedly increased - pulse rapid (140) and not of good quality. Feels very weak. Mentally much more dull. Liver not enlarged. Spleen enlarged and hard. Blood film - very heavy infection - B.T. gametocytes. 11.30 a.m. 20 cc Lodinin I.V. 1 cc. Rodealin I.M. 12.00 .... 20 cc Lodinin) 1 cc Pituitrin) I.V. 5 grs. Quinine Bihydrochlor.) 12.15 p.m. 1 cc Pituitrin I.M. - considerably shocked. 12.30 p.m. Pulse returning slightly. Complains of difficulty in breathing. 3.p.m. Comatose - Pulse not obtained. Heart sounds rapid and distant. Some respiratory difficulty. Limbs cold. Prescribed - Coramine 2.c.c. I.V. 5 p.m. Respirations very irregular. 5.30 p.m. Ceased to breathe.	

G.C. Gray, Captain,
R.C.A.M.C.

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CASE NO		NAME OF DIAGNOSING DOCTOR		Captain G.C. Gray, R.C.A.M.C.	
UNIT	Winnipeg Grenadiers.	NATIONALITY	Canadian.	NAME AND RANK	BADGER, George. Private. Age:- 21 years.
NAME OF DISEASE	Malaria B.T.	DATE ADMITTED	28.10.43.	DATE Died ~~DISCHARGED~~	5.30 p.m. 5.11.43.

DATE	TREATMENT	REMARKS
28.10.43.	Admitted. Headache. Generalised Abdominal aches, occasional shivers. Loss of Appetite - 3 days. Companions noticed interic tinge of sclera yesterday. Temperature on admission - 100 F. Bowels open No previous Malaria known. Sclera definitely ioteric. Tenderness over whole abdomen, particularly over upper abdomen. Spleen felt with Finger. Tenderness in Epigastrium just below costal margin and to right of mid-line. Temperature 101.2 F. p.m. Blood film taken.	
29.10.43.	Temperature normal this .a.m. Blood Film - B.T. Malaria. Prescribed - Quinine grs v t.i.d. for 8 days. LIGHT DIET.	
30.10.43.	Temperature 100 F. p.m. Normal a.m. Pulse 80.	
31.10.43.	Temperature 99.2. p.m. Normal a.m.	
1.11.43.	Temperature - Normal p.m. and a.m.	
2.11.43.	P.M. 99.2.F. No bowel movement since admission. Occasionally vomiting. a.m. Temp. 98.2.F.	
3.11.43.	Temperature Normal. Prescribed - Mag. Sulph. stat and in a.m. Jaundice less.	
4.11.43.	Temperature normal. No bowel movement up till to-night. Prescribed - Soft Soap Enema - good result.	
5.11.43.	Temperature normal - patient appears much worse in last 24 hours. Jaundice has markedly increased - pulse rapid (140) and not of good quality. Feels very weak. Mentally much more dull. Liver not enlarged. Spleen enlarged and hard. Blood film - very heavy infection - B.T. gametocytes. 11.30 a.m. 20 cc Lodinin I.V. 1 cc. Rodealin I.M. 12.00 .... 20 cc Lodinin) 1 cc Pitüitrin) I.V. 5 grs. Quinine Bihydrochlor.) 12.15 p.m. 1 cc Pituitrin I.M. - considerably shocked. 12.30 p.m. Pulse returning slightly. Complains of difficulty in breathing. 3.p.m. Comatose - Pulse not obtained. Heart sounds rapid and distant. Some respiratory difficulty. Limbs cold. Prescribed - Coramine 2.c.c. I.V. 5 p.m. Respirations very irregular. 5.30 p.m. Ceased to breathe.	

G.C. Gray, Captain,
R.C.A.M.C.

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Report on the Post Mortem Examination made at 10 a.m. on 6.11.1943 at Shamshuipo Prisoners of War Camp on the body of the late 4633 PTE. BADGER, G. Winnipeg Grenadiers, Aged 21 yrs, who died at 5.30 p.m. on 5.11.1943.

- -

General Appearances

The body was well developed but poorly nourished. Jaundice and Post Mortem Lividity were present but there was no Rigor Mortis.

Chest

Clear fluid was present in both pleural sacs. The left lung showed an old, well-healed apical tuberculous lesion adherent to the parietal pleura. The right pleura showed recent interlobular adhesions. Both lungs showed much congestion and pus in the bronchi but there was no consolidation. The heart was flabby and distended but the pericardium and endocardium were healthy. The coronary arteries and aorta showed very early atheroma.

Abdomen

The peritoneum and alimentary tract were healthy. The liver was of normal size and fairly firm but a deep yellow colour with haemorrhages. The gall-bladder, bile ducts and pancreas were all healthy. The spleen was slightly enlarged and very firm. The kidneys and bladder were healthy.

Cranium and its contents were healthy to the nakedeye.

Microscopic Examination of the splenic pulp showed parasites of benign tertian malaria.

Summary

I am of the opinion that death was due to:-

1. MALARIA. B.T.
2. SUB-ACUTE YELLOW ATROPHY OF TH E LIVER.

J.S. Allan Gray
Major, R.A.M.C.

Shamshuipo.
6th November, 1943.

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00113

Admn. No. 1391. Name of Doctor. Major J. Durran. H.K.V.D.C.

UNIT. Winnipeg Gren. Nationality. Canadian. Rank. Private.
Name. LaPlante. G.D.

Diagnosis :- Chronic Colitis. Admitted on 12.10.1943.
Discharged on 22.11.1943. (DIED).

		Course of Disease and Treatment.	Remarks.
1943. Oct. 12.		Admitted British Military Hospital.	
		Very emaciated. Skin dry. Tongue smooth and pale.	
		Chest. NAD.	
		Abdomen:- tender descending colon.	
		Nervous system. Numbness of feet. Reflexes :- knee jerks.) ankle jerks.) Absent.	
		Sensation - Diminished. Legs and feet.	
		Mental condition. Normal.	
Oct 13.	B.O.4.	Liquid stool. No blood or mucus.	
" 14.	B.O.4.	Stool. N.A.D.	
" 15.	B.O.6.		
" 16.	B.O.2.		
" 20.	B.O.1.	Much better. Appetite improving.	
" 22.	B.O.2.		
" 27.	B.O.1.	Sitting up.	
" 30.	B.N.O.	Up in chair. Feeling much better.	
		BLOOD :- R.B.C. 2,730,000.	
		H.C. 50 per cent.	
		C.I. 0.8	
		W.B.C. 5,800.	
Nov 3.	B.O.1.		
" 4.	B.O.4.		Ferri.Sulph.pil. 1x 3.
" 5.	B.O.2.		
" 6.	B.O.4.	Not so well. Iron disagreeing.	Stop Ferri.Sulph.
" 8.	B.O.1.	Weight. 92 lbs.	
" 10.	B.O.5.	Stool - Negative. No worms.	
" 14.	B.O.2.	Chest - Dullness - tubular breathing right base.	
" 15.		Blood Pressure - 95/55. No phlegm.	
" 18.		Chest seems better. Very weak.	
" 19.	B.N.O.	Very feeble. Appetite very poor.	
		Temperature persistently subnormal.	
" 20.		I.S.Q.	
" 21.		A little brighter in the afternoon.	
" 22.		A very poor night.	
		At 9 a.m. breathing became Cheyne-Stokes in character.	
		10.30 - DIED.	

RESULTS OF POST MORTEM EXAMINATION :-

Broncho-pneumonia - right base.
Liver.- spleen very small.
Bowel.- Pale and atrophic - Chronic Colitis.
Heart.- Pale and small.

Major H.K.V.D.C.

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CASE NO		NAME OF DIAGNOSING DOCTOR		Lieutenant S.[illegible] Bard, H.K.V.D.C.			
UNIT	H.K.V.D.C.	NATIONALITY	British.	NAME AND RANK	FORSYTH, William Rennie Private.		
NAME OF DISEASE	Duodenal Ulcer. (1) ~~Peri-Gastric Abscess.~~ (2) Localised Peritonitis. (3)	DATE ADMITTED	19.11.43.	DATE Died. ~~Discharged~~	23.11.43. 7.55 p.m		

DATE	TREATMENT	REMARKS
19.11.43.	Patient admitted suffering from severe pain in the abdomen. Has had a long history of dyspepsia extending over 4 years, and was under treatment all the time he was in camp. Had been in Bowen Road Hospital twice but nothing definite could be found to establish the diagnosis. There was a history of haematemasis. Pain bore no relation to food and was especially marked over the back. He had returned from Bowen Road Hospital on	12.11.43.
19.11.43.	Special Light Diet.	On examination generalised tenderness over the abdomen,
20.11.43.		but no rigidity. Fair night. Pain not severe.
21.11.43.	Atropine grs 1/75 MI. No food by mouth. Glucose IVI 25 cc of 20% Calcium inj. IVI.	In the afternoon pain became very severe; abdomen tender especially in right hypochondriac region. Pulse 78/min. Temperature normal. Vomited small amount of brownish-cherryed blood.
	10 p.m. Morphia grs ¼; Atropine gr 1/100 MI.	Pulse 130/min. Condition poor.
22.11.43.	Glucose 25 cc of 20% IVI at 9am. 2pm and 7 pm. Morphia grs ½ and Atropine grs 1/100. Alsilin 3tabs tds.	Fair night. Pain less. Pain present throughout the day. No temperature and no rigidity
23.11.43.	10 a.m. Glucose 25 cc of 20% IVI.	Still some pain present.
	Glucose 25 c.c. of 20% IVI.	In the afternoon pain became
	Camphor in oil inj. IMI.	very severe. Marked in the right iliac fossa. Temperature normal
	Post Mortem examination performed on 24.11.43 at 10 p.m. Large ulcer was discovered in the 1st part of the duodenum with localised peritonitis and peri-gastric ulcer.	Pulse very weak. Condition deteriorating. 7 pm patient moribund. 7.55 pm. Patient Died.

[signature]
MAJOR, I.M.S.
SENIOR MEDICAL OFFICER.

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Report on the Post Mortem Examination made at 10 a.m. on 24.11.1943 at Shamshuipo Prisoners of War Camp on the body of No 4007 PTE FORSYTH, WILLIAM RENNIE, Aged 39 years of the HONG KONG VOLUNTEER DEFENCE CORPS who died at 7.55 p.m. on 23.11.1943.

- -

General Appearances

The body was poorly nourished. Post Mortem Lividity and Rigor Mortis were present. There were no wounds.

Chest

Diffused recent adhesions were scattered over the right apex and over the left lung. The lungs were congested and the bronchi contained pus but there was no consolidation. The heart and blood vessels were healthy.

Abdomen

Generalised peritonitis was present arising from an abscess on the anterior aspect of the duodenum. The abscess was bounded in front by the lower surface of the right lobe of the liver and the hepatic flexure and behind by the duodenum. It was 3 inches in diameter, contained brown fluid and into it opened an ulcer on the antero-superior aspect of the first part of the duodenum immediately distal to the pylorus. The ulcer was nearly circular in shape, ¾ inch in diameter, had markedly indurated and thickened edges, and showed a minute bleeding point in addition to the opening into the abscess. Around the abscess the tissues were markedly inflamed and friable. Although the gall bladder itself was not inflamed, its tip had been pulled down and to the left to become adherent to the lesser curvature of the stomach. The liver and kidneys were toxic. The stomach, spleen, pancreas and intestines were healthy.

Summary

I am of the opinion that death was due to:-

1. Perforation of Chronic Duodenal Ulcer.
2. General Peritonitis.

J. D. Allan Gray

Shamshuipo.
24th November, 1943.

Major, R.A.M.C.

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CASE NO		NAME OF DIAGNOSING DOCTOR		Lieutenant A.L. Rodrigues, M.L.V.D.C.		
UNIT	M.K.V.D.C.	NATIONALITY	British.	NAME AND RANK	Sergeant WHITAKER, William Hedley.	
NAME OF DISEASE	1. Malignant and Benign Tertian Malaria. 2. Broncho-Pneumonia.	DATE ADMITTED	17.8.43.	DATE DIED DISCHARGED	8.20 p.m. 7.12.1943.	

DATE	TREATMENT	REMARKS
17.8.43.	Admitted to Hospital with Colitis for observation. No Blood or Mucus present. Transferred to General Ward on 19.8.43.	Fluid Diet.
21.8.43.	Placed on Extra Food and Milk with general improvement in weight. From 107 lbs to 119 lbs on 25.10.43.	
1 .9.43.	Early Stomatitis and Pellagra Scrotum.	10 Nicotinic Acid Tablets cleared this up.
14.1 .43.	Sent to Special Diet Ward . Suffering fro flatulence.	
.11.43.	Anaemia and Feet swollen. Blood taken negative result.	
11.43.	Oedema spread to abdominal cavity. Blood re-taken - L.F. Rings and B.T. Gametocytes found.	Rodigline 1 cc injected daily. Urine examination showed no albumin. Temp. p.m. 104.F.
1.1 .43.	Quinine grs 10 injected a.m. Orally grs 10 p.m. Temp. 105. F.	
.12.4 .	Temperature 103.6.F. Quinine injections grs 10 continued B.D. Temp 104.6. p.m. Aspiring grs 10 and Hot Sponge . gr. Morphine bed time.	
1.1 .43.	Temperature Normal. Blood re-taken. Still parasites present. Cough present. Soya Milk and Milk with Ovos 2 hourly.	
1.1 .43.	Temperature a.m. 9 .6.F. 5 p.m. 102.2. . Sore Coughing.	
1.1 .43.	Temperature 102. . Atebrin given t.d.s. grs 10 and Mistagin grs 10 b.d. Rodigline injection daily. Chest of pain and rhonchi.	
1.1 .43.	Left Side- broncho-pneumonia. Injection Quinine but to preserve required bulk.	
7.1 .43.	Blood re-taken. Still full of parasites - Broncho-Pneumonia all over. 1.30p.m. respiration weak and shortness of breath. Rodigline	

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S.I.P.O.

CASE NO		NAME OF DIAGNOSING DOCTOR	Staff Sergeant A... Rodrigues, R.A.M.C.		
UNIT	H.K./.D.C.	NATIONALITY	British.	NAME AND RANK	Sergeant [illegible]. William Dodley.
NAME OF DISEASE	1. Malignant and Benign Tertian Malaria. 2. Broncho-Pneumonia.	DATE ADMITTED	17.8.43.	DATE Died. ~~DISCHARGED~~	8.20 p.m. 7.12.43.

DATE	TREATMENT	REMARKS
	Injection - Morning. Atropine Grs 1/100. Temperature 5 p.m. 100 F. 8 p.m. Injection Radialine Cheyne-Stokes Breathing and accessory breathing. Passed away 8.20 p.m.	

[illegible]
Major, R.A.M.C.,
Senior Medical Officer.

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CASE NO		NAME OF DIAGNOSING DOCTOR	Captain G. F. Bolton, R.A.M.C.		
UNIT	H.K.V.D.C.	NATIONALITY	British	NAME AND RANK	Company Sergeant Major BASKETT, PAUL EVERY.
NAME OF DISEASE	1. Benign Tertian Malaria. 2. Lobar Pneumonia. 3. Cardiac Failure. (Beri Beri & Pellagra)	DATE ADMITTED	16.7.43	DATE DIED DISCHARGED	3.25 p.m. 9.12.43

DATE	TREATMENT	REMARKS
16.7.43	Complained of Oedema of legs, no breathlessness Previous History. Wet Beri-beri Sept. 1942 Pellagra July 1942 On examination. Legs swollen still some pellagra rash. No sore tongue. Bowels regular.	Daily injection Thiamin Grs. XX.
17.7.43	Feet much less swollen. Condition good.	
7.8.43	Still some oedema of legs.	
18.8.43	Oedema after exercise.	
28.8.43	Left foot still swollen.	
30.8.43	Foot still swollen.	
2.9.43	Complained of foot drop right leg. Anaesthesia over external Popliteal nerve distribution. Slight loss of joint sense to toe movement. Knee and ankle jerks present. No spasticity plantar reflex not expension. Weakness of all movements of the limb. Some wasting. Area of numbness over sacrum, groin, abdomen, and left leg not affected. Cranial nerves not affected.	
19.9.43	Right leg rather stronger but still has foot drop and weakness.	
7.10.43	Support for foot drop constructed.	
7.10.43	Oedema now gone. Discharged.	

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CASE NO		NAME OF DIAGNOSING DOCTOR	Captain G. T. Bolen, . K. V. D. C.		
UNIT	W.K.V.D.C.	NATIONALITY	British	NAME AND RANK	Company Sergeant Major BASKETT, Fred Evelyn
NAME OF DISEASE	1. Benign Tertian Malaria. 2. Lobar Pneumonia. 3. Cardiac Failure. (Beri Beri & Pellagra)	DATE ADMITTED	16.7.43	DATE DIED DISCHARGED	5.25 p.m. 9.12.43

DATE	TREATMENT	REMARKS
11.10.43	Septic spot on right leg.	
16.10.43	Both legs still very oedematous. Sepsis remains.	
1.12.43	Developed malaria. Blood positive to Benign tertian rings.	Quinine grains V. 8ds. given
7.12.43	Complained of pains in chest, cough. Consolidation of both bases of lungs Diagnosed Pneumonia Lobar	Sulphapyridine 1 grm. T.D.S.
8.12.43	Feeling rather better at mid-day. Sudden collapse at 4 p.m. Injection Coramine given. No response. Died at 5.25 p.m.	Sulphapyridine 1 grm. T.D.S.

Major, I.M.S.,
Senior Medical Officer

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Admission Number. 987. Name of Doctor. Major J.D. Fraser, R.A.M.C.

Unit. Dockyard Defence Corps. Nationality. British. Rank. Private.
Name. WHYTE, SAMUEL.

DIAGNOSIS :- CHRONIC NEPHRETIS. ARTERIO SCLEROSIS. AVITAMINOSIS. Admission. 28.10.1942. Date of Discharge. DIED. 13.10.1943.

	COURSE OF DISEASE AND TREATMENT.	REMARKS.
28.10.1943.	Admitted from Prisoner of War Camp, Shamshuipo, with history of pain and photophobia of left eye of two months duration. Sore tongue, gums and lips. 10 days duration. Stiffness of knees, ankles and wrists. Shooting pains. 6 months duration. Loss of weight and appetite. PATIENT'S PAST HISTORY :- Dysentery. 1936 and again in July and December, 1941. ON EXAMINATION :- Central Corneal Ulcer - Left eye. Angular conjunctivitis - Both eyes. Central Nervous System :- Deep reflexes increased in arms and diminished in legs. Vibration absent at ankles. Muscle tenderness both calves. Rhombergism positive. Numbness to pin prick below knee. Cardiovascular system :- Pulse regular. Vessels palpable, cardiac dullness normal. Cardiac sounds pure. B.P. 142/90 mm. Hg. Respiratory System :- N.A.D. Alimentary System :- Angular Stomatitis. Glossy smooth tongue. Skin :- Scrotal Excema. Pigmented scaly condition of pressure points.	Fr. Normal Diet, Extras. Thiamine Chloride. Yeast. Atropine. Pad and Bandage to eye.
11.11.43.	Corneal ulcer slow to heal leaving central opacity. Vision. V.A.R. 2/60. V.A.L. 2/60. Posterior Cortical Cataract. Feet - Very painful, preventing sleep. Nocturnal frequency micturation.	
10.12.43.	Tachycardia. B.P. is now 108/74. Balance better. Tenderness of calves still marked. Cramps in legs and thighs.	
15.2.43.	I.S. . except for septic vesciles of hands and feet. Weight increased.	
20.6.43.	Swelling of feet at night. Loss of weight. B.P. Low. 90/54.	
30.8.43.	Has now lost 15 lbs in weight. B.P. Varying between a low (74/44) and (high) 138/82). Vision. I.S.C.	
10.10.43.	Complaining of fainting fits and a contiued loss of weight. More marked ~~xxxxxxxxxxx~~ frequency of micturation. Urine contains trace of albumen. Nil else abnormal. B.P. 152/92.	
12.12.43.	Evening - 12.45 am - Had two epileptiform convulsions. Cheyne-Stokes breathing. Noisy and restless. Semi-comatosed. Heart sounds full. B.P. 210/110. Hyocine. grs 1/100th. 10 a.m. B.P. 240/110. Venesection. 15 ounces of blood removed. B.P. 165/90. Still comatosed. 3 p.m. Lumbar Puncture - Pressure 110 mms. Fluid clear. 9. p.m. Lies on any side. Limbs stiff and resistant. Pulse irregular.	
13.12.43.	12.30 a.m. PATIENT DIED.	

RESULT OF THE POST MORTEM EXAMINATION ON THE BODY OF THE LATE PTE. S. WHYTE.

Brain.	General venous engorgement. General oedema. Atheromatous plaques of arteries.
Heart.	Ventricles hypertrophied. Mitral valve thickened. Sub-endothelial haemorrhages of left ventricle. Patchy fibrosis of aorta.
Lungs.	General venous congestion.
Kidneys.	Small; fibrosed. Sclerosis of vessels - evidence of chronic nephritis.
Spleen, Liver and Bowel.	N.A.D.

J.D. Fraser
Major R.A.M.C.

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CASE NO		NAME OF DIAGNOSING DOCTOR	Captain G.C. [illegible], [illegible].C.A.M.C.		
UNIT	[illegible].	NATIONALITY	Canadian.	NAME AND RANK	[illegible], [illegible]. [illegible].
NAME OF DISEASE	[illegible] s.	DATE ADMITTED	[illegible]	DATE DISCHARGED (Died).	[illegible]

DATE	TREAT MENT	REMARKS
[illegible] (Continued)	[illegible] hiccough. [illegible] [illegible] ordered to be sed at noon.	[illegible] : Location [illegible] c.c. [illegible] V.S. 11, 6, 7. 4 o.s. [illegible] per rectum twice. Diathesis [illegible] c.c. [illegible]. Rectum [illegible] c.c. [illegible].
[illegible]	[illegible] ordered on [illegible]. [illegible]. [illegible]. Pulse [illegible], [illegible] [illegible] stronger. [illegible] stools. [illegible] vomiting. [illegible] urine [illegible] hours. [illegible] [illegible] collected. Abdominal [illegible] co-operation. [illegible] [illegible] times. Spirits [illegible] [illegible] flask administered. [illegible] respectively [illegible] [illegible] with [illegible] respiration [illegible] condition of pulse.	[illegible] 4 o.s. [illegible]. During [illegible] [illegible] 16 ozs. fluids by mouth, (no [illegible] [illegible] [illegible] water) [illegible] ozs. per rectum.
[illegible]	[illegible] ordered. Pulse [illegible]. [illegible]. [illegible] [illegible] [illegible]. Quantity [illegible] [illegible]. [illegible] [illegible] [illegible]. [illegible] [illegible]. Restrictions [illegible]. [illegible] [illegible] [illegible]. [illegible] [illegible] [illegible].	[illegible] [illegible] [illegible] [illegible]. [illegible] [illegible] [illegible] [illegible].

[illegible]

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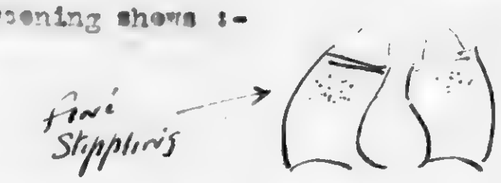
Case No	Name of Diagnosing Doctor or	Name and Rank.	Unit	Name of Disease	Date Admitted	Date Discharged or Died.	Treatment	Remarks
		Gandian.	R.R.C.	Acute Enteritis.	14.12.43.	13.12.43		

ADMISSION NUMBER :- 1305. NAME OF DOCTOR. MAJOR G.F. HARRISON. R.

UNIT. ROYAL AIR FORCE. NATIONALITY. BRITISH. RANK. L.A.C.

NAME. R.C. JACKSON.

DIAGNOSIS :- PULMONARY TUBERCULOSIS. DATE OF ADMISSION - 22.6.1943. DISCHARGE - 28.12.1943. (BY DEATH).

DATE.	COURSE OF DISEASE.	TREATMENT.
22.6.1943.	Admitted from Shamshuipo Camp Hospital. Complains of general weakness and no energy. PATIENTS PAST HISTORY :- August, 1942. Dry Pleurisy. Was two weeks in hospital with fever and slight pain in the right chest. September, 1942 to December, 1942. In hospital with afternoon fever and pains in the right chest. cough but no sputum. HISTORY OF PRESENT ILLNESS :- Was admitted to Shamshuipo Camp Hospital in May, 1943, with general weakness and tachycardia a slight cough with almost no sputum. Has been breathless on exertion since December, 1942. Appetite alrights. Says feet feel rather numb. ON EXAMINATION :- Appears thin and wasted and rather pale. Tongue throat, clean. Heart appears normal. Lungs. Some fine crepitations are present under the right clavicle. Few distant crepitations under the left clavicle. There is some wasting under the right clavicle. Abdomen appears normal. Central Nervous System. Peter and sensation - normal. Knee reflexes present and Ankle reflexes absent.	(Tr. Complete rest in bed. Thiamine Chloride daily. All available extras incl. Milk).
23.6.1943.	X-Ray Screening shows :- 	
26.6.1943.	Blood Sedimentation Rate -- 96 mm. (Westergren).	
30.6.1943.	Laboratory Report on Sputum -- No Tubercle Bacilli seen.	
12.7.1943.	X-Ray Screening. Same appearance as before. Still no sputum.	
22.7.1943.	Laboratory report on Sputum -- TUBERCLE BACILLI PRESENT (GAFFKY No: 2)	
31.7.1943.	Blood Sedimentation Rate -- 66 mm. (Westergren).	
1.8.1943.	X-Ray Screening. Same appearance as before. WEIGHT. 101 lbs.	
18.8.1943.	X-Ray Screening. Same appearance as before.	
31.8.1943.	Blood Sedimentation Rate. -- 85 mm. (Westergren).	
11.9.1943.	Some crepitations in both lungs.	
27.9.1943.	X-Ray Screening. Same appearance as before. WEIGHT. 107 lbs.	
5.10.1943.	Blood Sedimentation Rate -- 86 mm. (Westergren).	
23.10.1943.	Does not feel so well. Bowels open 3 times last night.	(Tr. Oleum Chenopodium. 15 minims).
25.10.1943.	One worm passed.	
29.10.1943.	Still has rather poor appetite.	
3.11.1943.	Appetite is slightly better.	
8.11.1943.	Blood Sedimentation Rate -- 71 mm. (Westergren).	

TO SHEET NO. 3.

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421.08

L.A.C. R.C. JACKSON. R.A.F.O.C. DIED ON. 29.12.1943.

SHEET NO. 2.

13.11.1943. Onset of bronchitis. (Tr. Iodine around neck. Inhalations. Aspirin grs. 20 sos.)

18.11.1943. Still had much difficulty and pain on swallowing.

24.11.1943. Voice still rather husky.

6.12.1943. His voice is still rather hoarse. Weight. 97 lbs.

7.12.1943. Appetite still poor. Voice very husky. Throat feels sore again. Stools are loose. (Two or Three a day). (Tr. Cod Liver Oil 1/2 dr. a day).

8.12.1943. Lungs -- Crepitations are more widespread over both lungs.

14.12.1943. X-Ray Screening shows --

Lesion is worse than it was before.

17.12.1943. Throat much better. Voice is clearer.

20.12.1943. Weight. 95 lbs.

21.12.1943. Still having some diarrhoea. (Tr. Tannalbinum. 1 G. Noctc).

23.12.1943. Diarrhoea still continues. (Tr. Increase Tannalbinum to 3 doses a day).

Laboratory Report on Sputum -- "TUBERCLE Bacilli PRESENT (GAFFKY NO: 9)

24.12.1943. Pulse Rate -- 120. Appetite very poor. Takes a long time to eat his meals. Diarrhoea continues. (Tr. Change to Chloradyne. minims XXX).

26.12.1943. General deterioration of his condition. Respirations have increased markedly. Pulse is very feeble. Pulse Rate -- 140. Cough has increased but is very feeble. Emaciation worse. On examination of lungs - There are crepitations present in profusion over both lungs. [illegible]

27.12.1943. Voice very feeble and husky. Very little sputum but has frequent weak cough. (Tr. Morphine. Grs. 1/4. Nocte).

28.12.1943. Poor Night. Respirations extremely rapid. Heart -- Gallop rhythm.

AT 10.00 A.M. PATIENT DIED.

RESULT OF A POST MORTEM EXAMINATION ON THE BODY OF THE LATE L.A.C. R.C. JACKSON. R.A.F.

The pleura was adherent to the diaphragm and the chest wall on both sides. Pericardial fluid slightly increased.

Lungs -- both lungs showed the entire lung covered with multiple, diffuse, discreet, small nodules, rather like that of Miliary Tuberculosis. There was in fact very little normal lung to be seen.

Heart. Appears normal.

Liver. There were a few superficial nodules present on the surface of the liver.

Spleen. Large. Nodules present.

Kidneys. Appeared normal.

Abdomen. Abdominal glands much enlarged. Both Intestines showed multiple small tuberculous ulcers.

CONCLUSION :- DEATH DUE TO PULMONARY TUBERCULOSIS.

W Warren

S21/80

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00126

戦時日誌

昭和十七年三月

T(2)
R.A.F.

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00127

Mrs. Watanabe
a Japanese minister
who was in Shanghai

1951

1951

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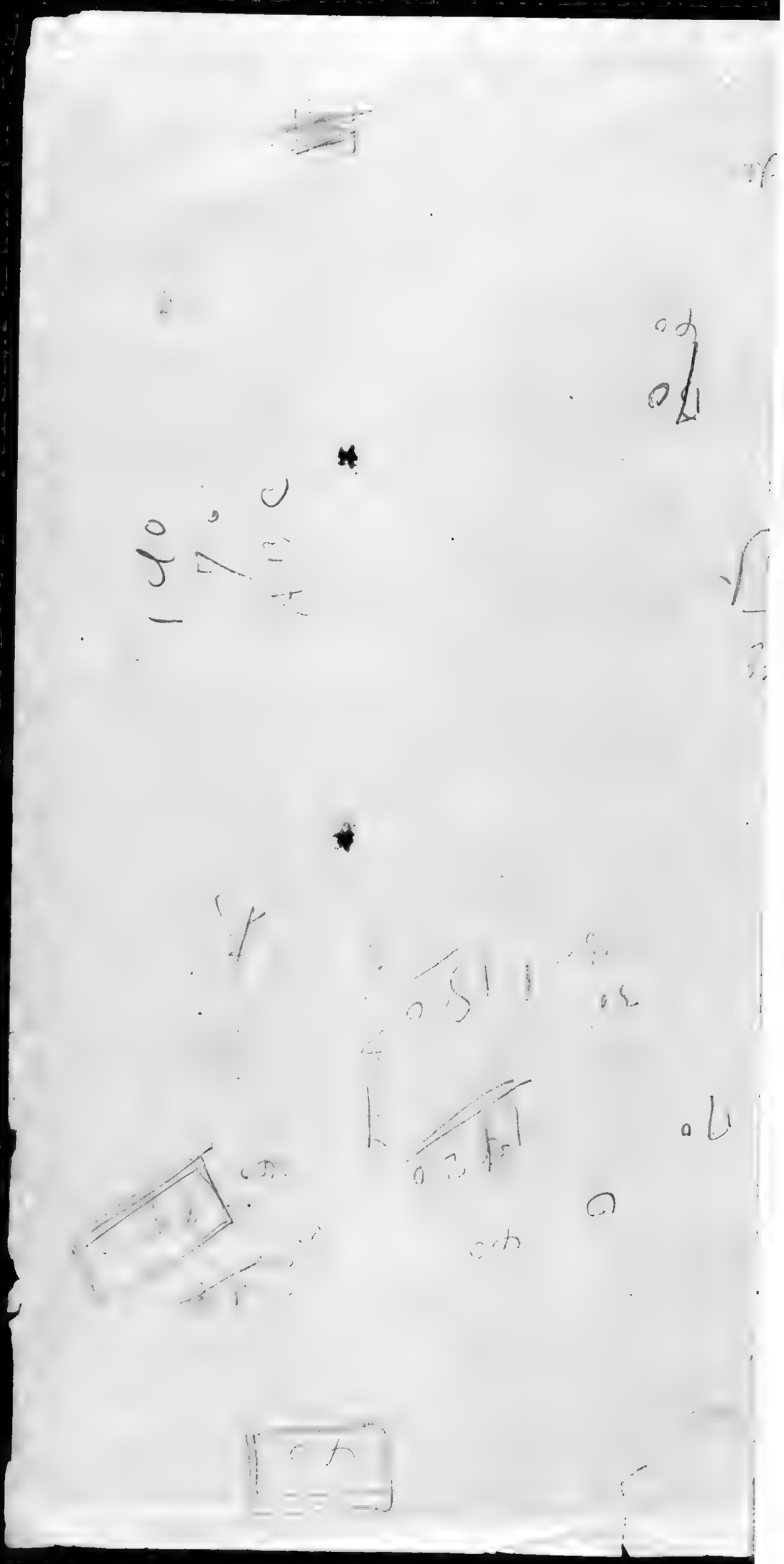
00128



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00129

番號	姓名	番號	備考
1	T. J. Rogerson,	29	
2	Kaggie. J,	30	
3	A.R. Green,	31	
4	G.C Keiowmy	32	
5	Fazal ahmed	33	
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00130

ハ院番号 No.	16065				
姓名 Name	2/Lt Hinjh Reg.	階級 Rank	INDIAN (Medical)	Corps. RJUNJARH M.S. I.M.S.	
病名 Disease	Dysentery Complicating chronic Malaria	入院日時 Date admitted	26.2.42	退院日時 Date discharged	DIED 5.50 P.M. 6.3.42
月日 Date	処置 Treatment				
4.3.42	Also getting heart trouble from Chronic Malaria with extreme secondary anaemia. Treatment. Hydrotherapy Local Massage with Glucose saline				

昭和17年3月11日死亡.

入院番号 Admission Number		診断医官名 Name of Doctor	Major D. Bruce Major G.F. Harrison RAMC.		
所属 Unit	R.N.V.R.	国籍 Nationality	British	階級及名 Rank & Name	Lieut: T.J. Rogerson
病名 Name of Disease	Chronic NEPHRITIS Heart FAILURE.	入院月日 Date of Admission	12.2.42	退院月日 Date of Discharge	Died 11/3/42 AT 1.40 am.

月日 Date	治療 Treatment	輸送区分	摘要 Remark
12/2/42	Rest. General Nursing.	STRelative.	General Condition Very Poor.
13/2/42	Lumbal Punct.		
15/2/42	Mist 2/15 t Zij Mist Expect Sleep.		Incontinent of Urine & Faeces
24/2	" " "		Urine 1/4 Albumen +++ Red Blood cells ++ Casts ++
2.3.42.	Enemas S.O.S. Zij tds. Mist Lact Bic & Pot Cit. Zij tds.		Blood Urea 125 mg%.
3/3/42		Delirious Delirium.	
10/3/42	Morphia gr 1/4. Nocte.		
11/3/42	Died AT 1.40 a.m.		

昭和17年3月11日午前1.40時死亡

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60131

No.	3054536		NAME OF DISCHARGING DOCTOR		Captain B.I.Evans
UNIT	Royal Scots	NATIONALITY	British	RANK / NAME	Private Haggie J
NATURE OF DISEASE	Dysentery Bacillary	DATE ADMITTED	6.3.42	DATE DISCHARGED	died 11.3.42

DATE	TREATMENT	REMARKS
6.3.42	Patient brought in to Hospital in a poor condition having had diorrhoea for one week. Treated with Dagenan, 4 tablets stat 2 tablets four hourly for three days. Mist Bismuth 1 oz four hourly.	
11.3.42	Condition poor - having collapsed at 8.45.am given intravenous Saline 2 pts, condition temporarily improved - relapsed 4pm, became comatove and died B. for Evans Capt: I.M.S.	

7.31 昭和17年3月11日14時45分死亡

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昭和17年3月24日死亡.

入院番号 Admission Number	CANADIAN 190		診断軍医名 Name of Doctor	Lt-Col D.C. Bowie R.A.M.C.	
所属部隊名 Unit	Winnipeg Grenadiers	国籍 Nationality	Canadian	階級氏名 Rank and Name	Cpl A.R. Green
病名 Name of Disease	GUN-SHOT WOUND PERINEUM. COMPOUND FRACTURE PELVIS	入院月日 Date of Admission	12.1.42.	退院月日 Date of Discharge	DIED 24.2.42.

月日 Date	治療 Treatment	輸送区分	摘要 Remark
12/1/42	Admitted from Royal N[illegible] Hospital. Wounded 14/12/41, in Perinaum. Rectum injured. Operation 29/12/41 – Left Inguinal Colostomy at R.N. Hospital. X ray – 8/1/42 showed Fracture of Superior Rami of ~~Left~~ Ischium R Operation – 15/1/42 – Bullet removed from ~~Left~~ R Buttock. When admitted here the wound in Right Ischio. Rectal region was fairly healthy. There was an opening into Rectum, the Left Ischio. Rectal foam was full of pus. A track led upwards into Pelvis. There was a Left Inguinal Colostomy. Treatment – The treatment was to Keep the wounds clean, to Keep the Colostomy functioning properly & to Keep up Patient's strength. The infection spread in the muscles of the thigh (L), and infection in the left hip joint which began in December spread. Patient failed to respond & died on 24.2.42 at 7 p.m. Ischio fem. Donald C Bowie Major RAMC		

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00133

入院番号 Admission Number		診断軍医名 Name of Doctor	Major Donald C. Dowie R.A.M.C.		
所属部隊名 Unit	R.R. of Canada	国籍 Nationality	Canadian	階級氏名 Rank and Name	Rfm G.C. Kellaway
病名 Name of Disease	GUNSHOT WOUND. RECTUM & THIGH (R).	入院月日 Date of Admission	20-1-42.	退院月日 Date of Discharge	16-3-42.

月日 Date	治療 Treatment	輸送区分	摘要 Remark
20-1-42	Admitted from Queen Mary Hospital. He had been wounded on 25-12-41 but no case record arrived with patient. On admission he had a wound on inner surface of Right Thigh opening into Right side of Rectum. The Right Thigh & leg were much swollen. There was a small wound Right side of Spine at level of 3rd Lumbar Spine. There was a Left Inguinal Colostomy which functioned well. Bare bone could be felt deep in the Pelvis in Sacrum. Treatment was directed to establishing drainage freely, to keeping good Colostomy function, & to nursing. Patient failed to improve. The rectal wound made no attempt to heal, & his condition deteriorated steadily.	Stretcher	
16-3-42	DIED. 4.30 a.m. Donald C. Dowie Major R.A.M.C.		

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Admission No. _____ 3 Name of diagnosing doctor Maj. Donald. C. Bowie R.A.M.C.

Unit : Punjab Regiment Nationality: Indian Rank & Name: Sepoy Fazal Ahmed

Nale of disease: GUN SHOT WOUND SHOULDER (L). Date Admitted 20 FEB 1942 Date Discharged 23 MAR 1942

DIED

月日 Date	治 才 Treatment	輸送區分	摘要 Remark
26.2.42	Adm. Military Hospital Bowen Road.	Stretcher	
	History — Wounded 18/12/41. ~~Upper~~ Head of Humerus (L) + Shoulder Joint (L) injured. Also Chin wound. Treated in Indian Hospital first at Tung Wah + then at St. Albert's. When St. Albert's closed he was fit only to move to Bowen Rd.		
	On Adm. — Septic Arthritis Lft Shoulder Joint + Acute Septic Arthritis Lft Knee Joint (Streptococcal). The Shoulder was treated in abduction splint + the Knee was treated by aspiration at first + incision later with Sulphonamide by mouth Also had a bed sore. The leg was later put in plaster. Progress was fair till 21/3/42 when he began to get worse. DIED. 23/3/42. at 6.10 a.m.		
	Donald C Bowie Maj RAMC		

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00135

No.	Unit		Diagnosing Doctor	Disposal
Unit	R.A.M.C. Corps	Nationality	British	Rank / Name
Disease	Beri Beri	Date admitted	4.4.42	Date discharged / died 5.4.42 11.30pm
Date	Treatment			Remarks
4.4.42	Admitted into hospital in a severe state of malnutrition with protein oedema of the legs – ascites and double pleural effusions at 8.30 p.m. ℞ Inj Thiamine Hydrochlor units 330 b.d ℞ Pot bitro gr 20 Tinct Digitalis m 15 Aqua ad 3ss. 3ss 6 hourly			
5.4.42	No appreciable change. 11.20 p.m. Saw the patient in an acute attack of heart failure and pulmonary oedema Inj. Digitalin gr 1/100 } administered Inj Atropine gr 1/100 } 5 mins. later patient ceased respiration & despite artificial respiration patient died at 11.30 p.m.			

B. I. Evans. Capt RAMC

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60138

入院番号 Admission Number		診断医師名 Name of Doctor	Major G.F. Harrison R.A.M.C.		
所属隊名 Unit	Winnipeg Grenadiers	国籍 Nationality	Canadian	階級氏名 Rank & Name	Lt. Colonel Sutcliffe, J.R.R.
病名 Disease	1. BERI BERI 2. DYSENTERY 3. ANAEMIA	入院月日 Date of Admission	2.4.42	退院月日 Date of Discharge	DIED 7.20 pm 6/4/42.

	治療 Treatment	転送の分	摘要 Remarks
		Stretcher	SEVERE Anaemia Dysentery. Beri-Beri.
3/4/42	Thiamin Chloride 20mg intravenously Bismuth Salicylate 3ss x 6. Fluids ++ — stools 4 doses. No ova or cysts. No amoeba Stool Blood +++ Mucus +++ Urine Nil Abnormal.		B.O. 12 hrs (Blood & Mucus)
4/4.	Thiamin Chloride 30 mg intravenously "HEPEX" 2 cc Subcutaneously. "Collosan" 3ii — 6 hrly. Stimulant + Opium ENEMA 3 pm. Sodium Luminal gr 5 Subcutaneously Fluids ++.		Vomiting. Condition worse. B.O. 12 hrs Blood & Mucus
5/4.	Thiamin Chloride 10mg Subcutaneously. Stimulant Treatment. Morphia gr 1/6 Nocte.		V. poor Night Condition worse.
6/4.	Thiamin Chloride 25 mg Subcut: Morning " " 25 mg Subcut: Afternoon. 1/100 gr Atropine 8.30 a.m. } 2 M10 1/100 Atropine " } Coramine 1 cc. " 1/100 gr Atropine 2.30 pm. " " " 2.30 pm. Will Strychnine gr 1/60 " " " 5 pm. Coramine 2 cc) 7 pm. Camphorated Oil) Patient DIED at 7.20 pm		Fluids ++ Failing

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入院番号 Admission Number		診断軍医名 Name of Doctor	
収容部隊名 Unit	Punjab Regiment	国籍 Nationality	British
病名 Name of Disease	G.S.W HEAD COMP. FRACTURE Skull. CERERRAL ABSCESS	入院月日 Date of Admission	18.1.42.
階級氏名 Rank & Name	Lieut: W.C.G. Gilmore		
退院月日 Date of Discharge	9 APR 1942 DIED.		

月日 Date	治療 Treatment	論文ニ方	摘要 Remark
18.1.42.	Admitted from Royal Naval Hospital where Subtemporal decompression had been performed 17 days after admitted there with depressed compound fracture of Skull.		Stretcher.
	On admission there much bone showing from G.S.W of vertex of head & also from Subtemporal decompression. Paralysis R arm & leg. Irritable: Chemotherapy.		
10.2.42	Improvement took place. with return of power of right arm & leg till 10.2.42 when he had a fit ? Jacksonian		
24.3.42.	Operation to relieve pus which had gathered round sequestra in both vertical & subtemporal skull wounds.		
	Improved for several days till condition deteriorated		
3.4.42.	Further operation with attempt to drain cerebral abscess. & left side.		
4.4.42	Deafness: paresis of right arm & leg. Nystagmus. ocular palsy. irritable deterioration of general condition ending in coma & paresis		
9.4.42	Death at 2.40 am. J Dawson Major RAMC.		

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		診断重医名 Name of Doctor	Majors Ross Duncan G. Fitzsimmons D. Bowie.		Hon. Lt.-Col. R.A.M.C.
	HIDDLESEY Reg.	国籍 Nationality	BRITISH	階級氏名 Rank & Name	No. 6201609 LAW. W.A.
		入院月日 Date of Admission	20.1.42	退院月日 Date of Discharge	10.4.42 DIED

Date	治方 Treatment	
21.1.42.	Dressing holes removed. Other movements to arm.	Walking
18.2.42	Stitches out.	
19.2.42	Bromide + Chloral. X. Ray skull. F.B. found	
25.2.42.	Transferred to medical ward for investigation	
28/2.	Special Mixture for headache.	
16/3.	Lumbar Puncture	
30/3	White Blood Count	
15/4	Lumbar Puncture	
10.4.42	Operation — Local Anaesthetic. Brain exposed. One metallic F.B. + 3 bone fragments removed from Left Occipital lobe of Brain. DIED 22.30 hours. Donald O'Bowie Maj. RAMC	

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died
11.4.42
(2000 hrs)

6·3·42 TRENCH MOUTH (SCURVY) TEETH SCALED + CLEANED. GUMS TREATED
to 4·4·42 CHROMICACID PAINT DAILY. DENTALLY FIT

G. Johnstone
Capt. R.A.D. Corps

10·4·42 9p.m. Developed a pyrexia and abdominal pain. Spleen slightly palpable + tender
Blood taken for M.P.
Mist Sodii Salicylas 3i given.

11a.m. Developed ~~prof~~ diorrhoea which got worse towards the end of the morning. Stools +ve Bacillary exudate. Transferred to Dysentry Ward. B.J. Evans
Capt. I.M.S.

2p.m. EXAMINED IN DYSENTERY WARD
DIETED.
MIST SODA SULPH TREATMENT.

7p.m. COLLAPSE WHEN AT STOOL.
CORAMINE & WARM FLUIDS.
INTRAVENOUS PREPARED BUT
PATIENT DIED BEFORE IT COULD
BE GIVEN.

A. Strahan
Capt RAMC

Major. I.M.S.
Commanding Base Stores Hospital.

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2/14 3e ż.

No	3353		NAME OF DIAGNOSING DOCTOR		CAPTAIN T. P. SUNDRAM I. M. S.
UNIT	H.K.S.R.A.	NATIONALITY	INDIAN	RANK	GNR
				NAME	AHMED KHAN
NAME OF DISEASE	PNEUMONIA LOBAR BOTH SIDES	DATE ADMITTED	20.4.42.	DATE DISCHARGED	20.4.42.

DATE	TREATMENT	REMARKS
	CORAMINE 1. c.c. HYPODERMICALLY	
	M & B. SOLUBLE INT. MUSC.	
	HYPERTONIC SALINE SUB. AXILLAR.	DIED. 1330 HOURS

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UNIT NUMBER	21194		NAME OF DIAGNOSING DOCTOR		Captain B.I. EVANS.. I.M.S.
UNIT.	5/7 Rajput Regiment.	NATIONALITY	INDIAN Hindu.	RANK AND NAME	Sepoy Ram Dhan Singh.
NATURE OF DISEASE	Pernicious Anaemia Complicated with Beri-Beri. + Malaria clinical.	DATE ADMITTED	11.4.42	DATE DISCHARGED	Died at 7.45 P.M on 21.4.42.

DATE	TREATMENT.	PROGRESS	Remarks
11.4.42.	Patient has been received with :- (a) EXTREME debility (b) Lips, tongue Conjunctivae showing pale colour of bloodlessness (c) Loss of Vision + looseness of bowels (d) Oedema of feet with loss of Sensation over TIBAE (e) Tenderness + Pain in Calf Muscles. (f) Spleen enlarged. THIAMINE 1 cc. Stat and Mist Pstas cit et Digitalis ℥ss TDS Absolute Rest in bed.	No improvement.	
12.4.42.	Treatment Continued.	Oedema + pain less. Sensation on lower Extremities Returned	
13.4.42.	Treatment Continued + Vitamin C. tablet. I.B.D.		
14.4.42.	THIAMINE 1/4 cc hypodermically and Mist Ferri et Ammon cit ℥ss TDS. (3 doses)	Oedema has disappeared: Pain with Regret in 3rd class Spleen Just palpable Pt to undergo Tr. for M.P.	
15.4.42.	—— do ——		
16.4.42	Mist Quinini ℥ss TDS		
19.4.42	Patient has stopped taking Nourishment and is Rather irresponsible in his attitude — is towards Anaemia Mist Ferri et Ammon Cit ℥ss TDS	Patient was conscious Conjunctival reflexes Lost Pulse feeble + weak.	
20.4.42	No improvement. — Blood for blood grouping for donors.		
21.4.42.	Patient fell down and sustained injuries on face + scalp + lost Considerable amounts of blood before Bleeding Controlled. Pure Milk Inoculated down — one Cc. Normal saline IPT given subcutaneously. Patient breathed his last at 7.45 P.M.	No suitable donor found. Hence No blood transfusion	

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CASE No 274

No	1		NAME OF DIAGNOSING DOCTOR		Captain B. I. EVANS I.M.S.
UNIT	5/7th RAJPUT REGIMENT.	NATIONALITY	INDIAN	RANK NAME	Cook RAM SARAN TEWARI.
NAME OF DISEASE	ANAEMIA II BERI BERI III PILES IV MALARIA, B.T.	DATE ADMITTED	20.4.42.	DATE DISCHARGED	

TREATMENT — REMARKS

Age :- 40 YEARS. SERVICE :- 22 YRS. RELIGION HINDU.

20.4.42. Patient has been received on a stretcher at 11.45 AM. Patient Complains of headache, marked prostration, palpitation pains in Calf & Thigh muscles and Swelling of feet.
Duration :- Two months.
In the past few days he has been getting fever with rigors and is now unfit to walk or do do anything.
Present Condition
Temp 100.4°. Pulse rate 110 + Respiration rate 22 p.m. Conjunctivae, lips + Tongue both bloodless. Skin & nails pale. Haemic murmurs +++
Spleen enlarged + 2" B.C.M.
Oedema of feet ankles and lower half of legs ++
with loss of sensation over tibiae + dorsum of feet.
Slight fluid in peritoneum
Extensor pile (anal) inflammed
Blood film revealed B.T. gametocytes +.
Mist Quinine ℥VI TDS
THIAMINE ½ cc daily :
Rest in bed.
Stools negative for ova or cysts.

23.4.42 Fever has now been Controlled. Oedema of feet + legs has Considerably diminished. Prostration still marked.
Mist Quinine ℥VI BD
Mist Ferri Ammon cit. (30 grs) ℈i TDS.
Thiamin ½ cc daily.

25.4.42. Extensor Pile has burst — oedema has nearly disappeared. Prostration still marked
Swab of Iodin paint on Extensor pile
Mist Ferri Ammon cit ℈i TDS
Mist Quinine ℥VI once daily

28.4.42 Blood 5 cc in blood grouping tablets — Death Rhesus negative
30.4.42 Patient is listless and keeps groaning with head in difference to his Surroundings - Pulse fluttering, weak. Breathing Stertorous
No Nourishment taken so far.

7.P.M. Condition hopeless. Breathing Stertorous. Patient moribund
Corneal reflexes lost. Pulse uncountable + Rapid + Very weak.

10.30 P.M. Patient breathed his last.

MAJOR- IMS

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No.	16025		Name of Diagnosing Doctor		Captain B.I. EVANS IMS
Unit	2/14th PUNJAB REGIMENT.	Nationality	INDIAN	Rank & Name	SEPOY PIARA SINGH
Disease	MAL-NUTRITION	Date admitted	2.5.42	Date discharged	DIED AT 7.05 P.M on 5.5.42.

DATE	TREATMENT	Remarks.

AGE :- 22 yrs Service 2½ yrs.

2.5.42 Patient has been received at about 2 P.M
Patient states that he has not taken any food during the past about seven days. About 15 days ago he vomited one round worm.
His Chief Complaint is Nausea and Vomiting immediately after food or drink.

Temperature 99.7. Pulse rate 102 + Resp 22 p.m.
Facies hypocratica with Sunken Cheeks and eyeballs.
Lungs Clear. Heart Normal. Liver enlarged
Slight Swelling and tenderness in the epigastrium.
Muscles flabby and powerless.
Knee jerks lost. Both Clonus ++. Plantar reflexes normal through rather sluggish.
Patient is considered to be in a Serious Condition.
Mist Alkaline Carminative ℥j T.D.S.
Nux 9 one tablet at 9 P.M.

3.5.42 Temperature normal this morning
Patient unable to sit or walk. Vomiting persistent
Passed one motion this morning.
Stool negative for ova, cysts. Expelled Mb.
Mist Salin ℥j 4 hrs. (Vomited out)

4.5.42 Dextrose 1gr brought 3 grs
Patient is not taking any nourishment. Dehydration marked. Vomiting Persists. Condition Dangerous
Morphine ¼ gr 4th hourly. Temp: 100 7. Pulse rate 120
Blood negative for M.P. Glucose Dehydrated 108 on 107 + Rectal Saline given.

5.5.42 Patient moribund. Corneal reflexes are lost
Patient not in coma. Pulse fluttering weak, + Thready
Respiration ½ 100 on abdominal type. Normal Saline Subcutaneously.
Patient died at 7.05 P.M.
PATIENT DIED AT 7.05 A.M

Lieut Colonel Surgeon Major 2nd Comdg: Nos: 3. Ind. Gen. Hospital

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NO. 2 HOSPITAL.

POST MORTEM - Pte.F. Bristow.

External Examination:- Body of young normal male, considerably wasted. P.M. lividity, no rigor mortis. Scattered petechiae over dorsum of feet and anterior chest wall. Burn left fore-arm.(H.W.B.) No gross edema of dependant parts or limbs. Circle of sores on foreskin.

Chest.

(1) Lungs. About 250 c.c. clear straw coloured fluid in pleural cavities. Lungs showed slight degree of passive congestion and were water logged. Small adhesion from right lower lobe to anterior chest wall. No evidence of recent or old chest disease.

(2) Heart.Pericardial fluid increased in amount. The Right Auricle thin and showed evidence of fatty degeneration. Right Ventricle the same. Right Auricle wall about mitral valve very fatty. Left Ventricle small. Cross section of muscle walls showed pale muscle - edematous in appearance. Mitral valve slight thickening of one cusp - not recent.

Abdomen. Peritoneal cavity full of clear straw coloured fluid.

(1) Liver. Normal size. Slightly congested. Capsule stripped easily.

(2) Spleen. Small wrinkled, capsule stripped easily. Section showed nothing abnormal. Small accessory spleen.

(3) Pancreas. Narrow, rectangular and exceedingly firm in consistency.

(4) Kidneys. Small, cortex pale. Capsule stripped easily. Bladder contained fresh urine 100 c.c. Normal.

(5) Stomach and small intestine. Normal and empty except for some small amount of yellowish mucoid chyme.

(6) Caecum and Colon. This part of the gut was thickened throughout its whole length. The mucus surface was smooth, thick and scarred. It was stippled with black pin-point deposits. One small ulcer was present in the mucus membrane of the pelvic colon. The caecum and ascending colon had numerous petechiae scattered over the surface, slightly raised and firm. No evidence of recent colitis.

(7) The mesenteric glands were slightly enlarged and injected.

Cause of death. Acute Cardiac failure with generalised anasarca secondary to a chronic colitis.

Surgeon Lieut. Commander. R.N.

6/6/42.

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5H100

NAME OF SICKNESS Dysentery. (B) Chronic & Acute Cardiac Failure. NATIONALITY British RANK Pte

UNIT Middlesex DATE OF ADMISSION 17/2/42 DATE OF ~~DISCHARGE~~ DEATH 6/3/42

NAME Riviston Frederick No. 6201510 34 NAME OF DIAGNOSING DOCTOR Lunn

Date	Treatment	Medicine	Demands
17/2/42.	Has had persistent diarrhoea, & abd. pain and bloody, mucous in stools. Has become very dehydrated. - duration 5-6 days. T+P. N. Fong Pin mist		
26/2/42.	State has frequent loose, blood stained stools. Tongue v. dry + dirty	Mag Sulph ʒj & aa	
27/2/42	Feels sl. better but is still unwell.	(4)	
28/2/42	N/A. Impr. sl. Still has diarrhoea.	Full & Biscuit	
1/3/42	M.T. 100° / P.R. 60. Complains of pain & painful haemorrhoids.		
2/3/42.	E.T. 100° N. P.R 96 Has past history of malaria - but has no enlarged spleen. Feels Hot + sweaty at onset + sl. headache & fever.	Quinine grs v & aa	
3/3/42.	Sl. improved -	Quinine grs iii 8 times daily	
5/3/42.	Headache.	B.P.C.	
7/3/42.	Some pain. Diarrhoea is quite unchanged has regular swinging E.T.		
8/3/42	Some diarrhoea - still. Some improvement.	N.T.	
9/3/42	Daily E.T. - No change in frequency of bowel movements. P.R increased in evening	Full (1) Emetine grs 1/3 daily for 10 days	
10/3/42	T.N. & P.R. bulletin. - Diarrhoea still present		
11/3/42	E.T. 101. Some headache & pains when fever rises.		
12/3/42	E.T. 101 now comfy. Dressings. Healing perineal wounds - Chest moves +. P.R normal right upper zone. Bk. bronchial & prolong → phase. Occ. rales. W.P. +. over right upper zone Fluoroscopy: Unsatisfactory but? soft infiltration Right upper zone.	(1) Emetine grs 1/3 daily 10 days ~~Quinine grs v t.d.s.~~	

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Bialow.

DATE	TREATMENT	STATE OF TEMPER	REMARKS
4/4.	Complains of weird. Has some improvement in looks.	Up in chair	Full.
5/4	N/c. ① Lenic. Mist. ~~D.S.~~ N.T. ~~B.C.~~	—	—
6/4.	Had onset of diarrhoea & vigor + fever during the night. B.O. V. ① ~~Mist.~~ Tinct. Op. & Belladonna. ~~B.D.~~ A.C	B	Fluid diet.
7/4	Improved Sl. Slept quite well. ② Morphia gro 1/4 Q4H. P.R.N. ~~Lots~~		
8/4.	Improved. diarrhoea better but. P.R. still present. looks better. N.T.	S/B.	Fluids
9/4	Improved. N.T.	S/B.	Fluids
10/4.	B.O. VII - Feels better. ① Water 6 pts daily or other fluids ② Yeast ℥j daily.	S/B	Fluids
11/4.	Better. Eating well found he can get more! ①	S/B	Full diet.
12/4	Improving ① - ② ~~Compound~~	S/B	Full
13/4	T. + P. N. B.O. IV V.L. Blood appetite better ① - ②	S/B	Full
14/4	N. B.O. 2. Some blood better. ① · ②	S/B	Full
16/4	Imp. Water 1ˢᵗ - 2ⁿᵈ yeast	—	—
20/4	~~KETN~~ E. T. 100 No special complaints. ② ℥j daily	S/B	Extra Vegetables.
21/4	① Yeast ℥j daily. ② Special Rx ℥j V.D.S. A.C.		
23/4.	T. N/A Fluid blood stained stools fairly frequently (1) Yeast — (2) Spec. mixture (3) Saline ~~retention~~ enema 4 ozs to pint daily	S/B	Novice All ground food
24/4	Rheumatic reference Lesion. (1) - (2) Spec. mixture once daily (3) Saline enemata B.D.	S/B	—
25/4.	V. Pale. But sl. improvement (1) - (2) - (3)	—	—
26/4	N/c. (1) - (2) - (3) 1/4 daily	S/B	—
27/4	V.L. Change. (1) Thiamin 1/2 c.c. daily. (2) Mist. Ferri Perchlor. TDS. after meals. (3) Daily Saline wash out.	S/B	—
29/4.	Complains of Abd. upset. (1) Thiamin 1/2 c.c. every 3rd day. (2) T.D.S. p.c.		

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Bistow.

月日 Date	治療方法 Treatment	食物 Diet	大便 Bowels
13/3/42.	Has had cough, diarrhoea & haemorrhoid trouble. Sweating. Is very emaciated & looks ill. (1) Diarrhoea mixture (2) Sometime gm ½ daily 6 hourly doses. Sputum. ? Acid Fast Bacilli present ++	S/Bed.	Full.
14/3/42.	Sl. better. temp down. Had several sweats during the night.	1 – 2	S/B.	Full.
15/3/42.	103 99. No special complaints Diarrhoea 19 times!	(1)	S/B	Fluids
16/3/42	N/N. P.R 108 - Abd wind. but much reduced.	B.O Sputum blood N.T.	S/B.	Fluids
17/3/42.	N/N. P.R. 108.	N.T	S/B.	Full & Fluids No Rice
18/3/42.	F.T.103 - Diarrhoea ++. Complains of wind. Diarrhoea is with out blood. No Tubercle bacilli found.	Sputum Stool N.A.D.		
	Had fever & sweating etc. last evening B.S. + over chest ant. & ? dim. movement over right side, posteriorly.		S/B	Full, Fluids No rice
19/3/42.	E.T. N + P.R. dropping.		S/B.	Full.
20/3/42.	N. T + P. Diarrhoea		S/B	Full
21/3/42.	Sl. evening. temp. B.O. VI. Looks better. V. pale.	(1) Charcoal. T.D.S	S/B	Full
22/3/42	N/N. Better	(1)	—	—
23/3/42	N/N. P.R. rapid.	(1) B.D. pm	S/B	Full
24/3/42	N/N. Pulse settling	(1).	S/B	Full
25/3/42	T.N/N 96 96. B.O. VI	N.T.	S/B	Full
26/3/42.	N/N.	N.T.	S/B	Full.
27/3/42	N/N.	N.T.	B	Full
28/3/42	N/N	N.T.	—	—
29/3/42	N/N.	N.T.	—	Full
30/3/42	N/N		Magnesia in tablets if fine.	Full - as breakfast unless he asks for it.
31/3/42	N/N. B.O. ½ improved generally	—		
1/4/42		N.T.	Syrup Chair	Full as above
2/4/42	N/N.			
3/4/42		N.T.	—	Full as abov

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Bistow.

日 DATE	治 方 TREATMENT	輸送区分	摘要 REMARK
30/4.	Legs v. weak + wasted. - Hea Chronic colitis now - no blood seen. ? pellicles over feet.	1. Thiamin ½ every 3rd day 2. Mist. Fusi Bismuth. TDS. ½ c.	2lbs up in Class	Full ground food
1/5	Balanitis & discharge.	1. 2. B.D. (3). Emol bath + dressing to penis.	—	—
2/5	Complains of great weakness. Wounds and sores clean but no blood + recently melena have been slightly formed. Appetite better. (1) Thiamin every 3rd Day. ½ c.c. (2) B.D. (3).		2lbs up in Class	Fluid & Full.
3/5.	Bowels better. to	(1) (2) (3)		diet ground food
4/5.	Abd. v. distended. Today. ē free fluid + ? pitting edema over sacrum + Dorsal enlargement. There is some improvement of Balanitis, sores healing	(1) 1 c.c. (2) (3) Tinct Digitalis mx XXX. B.D. (4) Emol dressing to penis.	Bed	Full. Ground restrict fluid 2 pints daily.
5/5.	No change - abd. v. swollen	(1). Tinct. Digitalis mx XX TDS. (2) C.L. Oil. B.D. (3) Emol dressing to penis.	Bed	Full. Diet. ē restricted rice.
6/5.	Had sudden collapse about 0730. today unconscious. generalised oedema. - Cheyne Stokes resp. Had four nights. Given 1 c.c. Lobygen & 1½ Coramine intravenously. Head of bed el. raised. + Hot bed bath to promote sweating. has had practically anuria for last 24 - 36 hours. 1. Repeat Coramine. 12 noon. 2. Keep hot + sweating if possible.			
	Died at 1330			
6/5	死亡診断書ヲ以テ1330ト認ム			

陸軍軍醫中尉 斎藤俊吉

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CAFN: 81

No	7642		NAME OF DIAGNOSING DOCTOR		CAPT. T. P. SUNDRAM. I.M.S.
UNIT	4th Med. Battery 1st HK. Regiment HKSRA	NATIONALITY	INDIAN	RANK NAME	Gunner KARTAR SINGH age 23
NATURE OF DISEASE	ANAEMIA & DYSENTERY	DATE ADMITTED	21.2.42	DATE DISCHARGED	DIED 7.5.42 at 9 pm.

DATE	Treatment	REMARKS.
(X) 23.4.42 ↑ 29.4.42	Emetine Hcl injections 6 (gri each) one every day. No appreciable improvement in the dysenteric symptoms. Patient unable to assimilate even liquid food.	
3.5.42	Acute intestinal colic with distension of abdomen Morphia ½ gr + pituitrin .5cc	
7.5.42	Patient became unconscious at 8 a.m. & was passing	DIED at 9 P.M. 7.5.42
27.2.42	Patient is terribly weak and emaciated Hb ½ microhaemoglobin. Conjunctivae and nails appear bloodless and white. He is unable to take food. Colon index 1.8 with Haemoglobin 25 %. Ascaris ova seen in stools.	J.P. Sundram Capt. I.M.S.
	I Mist Ferri et Quinini Citras ʒi TDS (30 gms)	
	II Cod liver oil ʒiss TDS	
7.3.42	one Round Worm male expelled after a dose of Carbon tetrachlor ʒj XXX grains in Liquid paraffin today.	
	Treatment with Ferri et Quinini Citras ʒi TDS	
	and Cod liver oil ʒiss TDS	
17.3.42	Hepatrol 10 cc daily for 3 days in addition to above	
24.3.42	Hepatrix 2 cc daily for 6 injections	
25.3.42	Blood [illegible] donated in this Laboratory.	
(X) 23.4.42	Response Satisfactory. Patient has developed dysentery. Transferred to dysentery Ward.	

[illegible]
Major I.M.S.
Comdg No: 3 P. of I. Hospital

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CASE No 213

No	10020		NAME OF DIAGNOSING DOCTOR	CAPTAIN T. P. SUNDRAM I.M.S.	
UNIT	2/14 P.R.	NATIONALITY	INDIAN	RANK	NK
NAME OF DISEASE	ANAEMIA (DYSENTERY)	DATE ADMITTED	17. 3. 42.	NAME	TIRATH RAM
				DATE DISCHARGED	DIED 12/5/42

DATE	TREATMENT	REMARKS
17.3.42.	LIQUID DIET	AGE 30 YEARS
	MIST. IRON TONIC. ℥i ℈ D.D.P.C.	
25.3.42.	MIST SALINE ~~℥ii~~ ℥iß EVERY MORNING	
	—"— ℥ii 2 HRLY.	
30.3.42.	MIST. BISMUTH ℥i B.D.S.	
2.4.42.	THIAMIN 1/2 cc SUBCUTANEOUSLY DAILY.	
9.4.42.	PATIET PASSED BLOOD & MUCUS. TRFD. TO DYS. WARD	
10.4.42.	EMETIN HYDROCHLORIDE GRI I.C. DAILY.	
17.4.42.	DIGITALIN GR 1/60 SUB. CUT. EVERY 4HRS.	
20.4.42.	MIST BISMUTH ℥i T.D.S.	
25.4.42.	M & B. TAB. 4 ONLY.	
28.4.42.	PATIENT'S CONDITION IS BECOMING WORSE AND WORSE DAILY	
30.4.42	HOT TEA AD.LIB. SUGAR WATER AD.LIB.	
12.5.42.	PATIENT EXPIRED AT 8 A.M.	DIED AT 8 A.M. ON 12.5.42

Lieutenant Colonel
Major IMS
Condy. No. 3 P.W. Hospital

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入院番号 Admission Number		診断医名 Name of Doctor	Major Donald C. BOWIE. R.A.M.C.		
隊名 Unit	H.K.V.D.C.	国籍 Nationality	British	階級及姓名 Rank & Name	Pte ~~Steinobt~~ STANESBY.
病名 Name of Disease	Carcinoma Bladder.	入院月日 Date of Admission	13 February 1942.	退院月日 Date of Discharge	DIED. 15 May 42.

月日 Date	治方 Treatment	輸送方	摘要 Remark
	This patient first had haematuria 18 months before admission. Admitted from Argyle St. Prisoners of War Camp suffering from Haematuria.		Stretcher
16.2.42	Cystoscopy – New growth present near left Ureteric orifice part of which at least was simple Papilloma. The view was much obscured by bleeding but ulceration suggested malignancy.		
	General condition very poor & attempts made to improve this.		
10.3.42	Operation – Supra-pubic exposure of Bladder. Superior surface of Bladder on left side occupied by a stony hard tumour. Bladder was adherent to Pelvis on left side & enlarged glands present along Iliac vessels. Bladder not opened as tumour was not removable.		
	The Japanese authorities were approached after operation to see if the Deep X. Ray Therapy unit at the Queen Mary Civil Hospital in Hongkong was still available for treatment of patients. The reply was that this apparatus was not available & this answer was repeated early in May 1942.		
	Patient's condition deteriorated & he died on 15 May 42 at 15.45 hours Tokio time.		

Donald C. Bowie Major
RAMC

陸軍軍醫中尉　澤田　巖

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入院番号 Admission Number		診断軍医名 Name of Doctor	Major Donald C. Bowie R.A.M.C.		
収容部隊名 Unit	Royal Engineers	国籍 Nationality	British	階級氏名 Rank & Name	Pte R.V. Stephens
病名 Name of Disease	Gun Shot Wound of Back	入院月日 Date of Admission	15.1.42.	退院月日 Date of Discharge	17.5.42.

月日 Date	治療 Treatment	輸送区分	摘要 Remarks
			Stretcher.
	Wounded by a bomb on 21/12/41 & treated in War Memorial Hospital Admitted – 15.1.42 suffering from a wound in region of 5th Lumbar Vertebra. In the left leg there was complete paralysis below the Knee & in the Right leg the Tibialis Anticus alone functioning below the Knee. There was complete paralysis of bladder on both sides with saddle shaped anaesthesia & complete loss of sensation in both legs. Complete retention of Urine & infection.		
19/1/42	Operation – a foreign body (metal) was removed from the left side of the Spinal canal after removing shattered laminae of 5th Lumbar Vertebra.		
	This operation led to no improvement & infection of bladder & Kidneys progressed. Condition deteriorated.		
	Much abdominal pain led to an exploration of wound on 14/5/42. The general condition was now very poor & he died on 17/5/42.		

Donald C. Bowie Major R.A.M.C.

陸軍病院中村 澤田 巖

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Religion Hebrew

入院番號 NO	No 115	診斷軍醫名 NAME OF DIAGNOSING DOCTOR	Lt. Surg. Com. Gunn.
部隊號 UNIT	H.K. V.D.C. (N.D.)	國籍 NATIONALITY	BR.
病名 DISEASE	① Malnutrition + Peripheral Neuritis ② Cardiac Failure.	入院月日 DATE ADMITTED	29.3.42.

階級氏名 RANK AND NAME: GUBBAY, Mrs

退院月日 DATE DISCHARGED: DIED 14-5-42.

月日 DATE	TREATMENT 治療方	輸送區分	摘要 REMARK
28/3/42.	Has been restless - unable to sleep and rather inclined to do unintelligent acts. She complains that she has a sore + very dry mouth and is unable to eat the normal diet and is very weak. There is no obsessive thirst. No pain of any sort. Has had to get up to pass water 3-4 times a night to pass water has a little diarrhoea. which is not serious. No other serious complaint. She drinks v. little fluid and is rather trying over her diet.		
	P.X. 1. Tonic. V.S. 2. Measure (intake & output)	B	Full
	This patient must have beans, meat, vegetable when provided in preference to primary suppliers of food. also Fluids to a total of 4 pints.		
30/3/42.	T. N/N. Is very incoherent. Has apparently eaten rather little meat. Bromide - having swallowed most of tonic in 24 hrs. Feeds twice. Now sleeping quietly. ② only.	S/B	Full
31/3/42.	N/V. slow mentally. Slept fairly well. This is mental deterioration. ? early. Inversion	N.T.	S/B	Full
1/4.	Is sl. better. Has diarrhoea - Eating better	① Sod Sulph. 3ij to ℞	S/B.	Full
2/4	Imp		S/B	Full
3/4.	Improving. Slept well. appetite & food.	N.T.	S/B	Full
4/4.	Improved considerably, mentally al. better + appetite improved.	N.T.	S/B	Full
7/4	Is eating well and is mentally quite alert. ? Increase in weight.	N.T. ① Pot Brom + Chloral gr x ℞ H.S.	—	—
8/4	N/c - not so good today	① p.r.n.	—	—
		Yeast ℥ij.		
13/4	Improving. Diarrhoea less	① Yeast ℥ij.	S/B.	Full
15/4	Passed Keichan. Last evening. Eating well. ? diarrhoea	① Yeast ℥ij. ① Santonin gr ss a.m. followed 2h later by ol. Ric ℥ss. light tea. ? Wheat flour.	S/B	—

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Mrs Lubbock

月日 Date	治療方法 Treatment		輸送區分	備考 Remarks
16/4.	Nouveau	① Repeat De-worming. ② Yeast 3/-		
17/4	Nouveau	① —②	S/B.	Full
18/4	Nouveau.	②	B.	Full
20/4.	Small aphtha over pharynx Large Epithelial Haemorrhoids	① Mag. Sulph. 4ss. in Water ② Haemorrhoid. Suppos 1 - B.D. P.R.		
21/4.	Improved.	①	B.	Full
22/4.	Improved generally. Still some sl. gastric upset. & evening fever.	① Yeast 3/- t.d.s.	—	—
23/4.	Improving.	(1) — (2) Homocitrocol & (2) tabs. T.D.S. 1 — 2 (3) Hot Foment to L of right jaw Q4H.	B.	Full
25/4.	Complaining of Sl. swelling over angle Right Jaw. Hard, ? parotid swelling. Glands			
29/4.	P. Brow & Chloral has stopped completely. Discontinued & fell well & had twelve during the night. Face is much easier & less painful.	① Hot Foment to L right Jaw Q4H. (2) Homocitrocol (2) tabs. T.D.S.		
2/5	Swelling over angle of jaw has shown considerable increase. It is larger than a walnut & parotid area of right side, including angle of jaw. It slightly tender, firm and no evidence of inflammation. There is slight sogginess over it. Mouth probably due to N.W.B & Hot fomento. Unable to open mouth to full extent but feed but succeeds pretty well with effort. Mouth v. dry. same complaint as before. Nothing palpable or to be seen on buccal surface. Salivary glands in neck but these have been present since admission. There is ? slight fullness of neck veins on right side. ? Parotid tumor.			

Would Dr. Newton please see?

WS

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Subbay.

DATE 月日	TREATMENT 治療方	輸送摘要 REMARK
3/5.	Face easier. Lt. fever. + some diarrhoea.	1. Hll. Sil & food. TDS. 2. Mouth wash Carbolic + Saline Q4H. 3. ~~Lotion Hyp. Perm. K. 1/5000~~ 4. Foment to jaw. Q4H. 5. Vitamin B; tabs. 4 Soft food. T.D.S. (6) Glycerine + Borax after each meal.	
4/5.	Discharging freely into mouth "Bad Smell" ? Sl. fluct. under angle of jaw. E.T. 101/N.	(1) -(2) -(3) -(4) -(5) (6) S/B	Fluids & ~~Soft~~ soft foods + meat.
5/5.	Has some diarrhoea during night. Right side of face easier. Much discharge from Stenon's Duct. There is V. tender swelling under angle of left jaw. Not present yesterday mouth much cleaner.	Must Turi Perchlor 3ii after food T.D.S. (1) -(2) (3) Foments to Right + Left side of face. (4) Vit. B$_1$ - 4 tabs T.D.S. c food (5) Glycerine + Borax after each meal	
6/5.	Much discharge from mouth (St. Duct). Right temp. easier. + Left side much easier. Condition good.	S/B	as above
		Q2H. 1 - 2 - 3 - 4 - 5.	S/B Full - minced.
7/5	E.T. 100/N. Not v. much change. Still discharging freely.	(6) Sulphathiazole ii Stat. repeat at 1200 + Q4H ① Foments to both sides of face. ② Glycerine + borax after each meal. ③ Mouth wash - Carbolic & saline Q2H. (4) Sulphathiazole ii T.D.S. (5) Hll. c food. (mxx)	—
	1900 Has not slept since 3.30. Very weak but not terribly distressed.	(1) -(2) -(3)	— Minced Diet No Rice
8/5.	W.B. - Pulse fair - not eating much. Fair amt of discharge. There is Large perf. behind last molar tooth, ? bone pus coming but appears to be coming from parotid Duct left side st. larger than on Entry today	(1) Foments Q4H. (2) Sulphathiazole ii T.D.S. (3) Mouth wash Q4H. (4) Chloral + Bromide aa gss ℥ H.S.	Minced Diet no Rice.

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95108

Subbay.

日付 Date	治療方法 Treatment	輸送区分	手術要否 Dressing
9/5.	Left frontal + V. V. tender.. Some discharge from right N.S. tender – Pulse v. poor.– Sulphathiazole taken last 24 hrs (and saline again) that it does not agree with her.	1. Mouth Wash. Q2H. 2. Flyc. + borax after food. 3. Fomento. Q2H. 4. Chloral + Brom. aa gss N.S. 5. Ceramine. 1cc. S.C. N.S.	
10/5.	W/H Improving. Right cells v. much better. Left. swollen + tender	1 – 2 – 3 Left only. 4.	S/B Full minced. & Fluids No Rice.
11/5	V. Weak feeler – rather brighter than before eating + drinking poorly. No change in glands.	1–2–3–4	S/B —
12/5.	V. L. change. eating + drinking better – some incontinence. Foul better.	(1) Q2H + after any food. (4)	S/B —
13/5.	Mouth better. Eating + drinking quite well. Foul unchanged.	(1) – (4)	S/B Full
14/5.	Mouth cleaner. less pus. Left side swollen v. tender + fluctuating.	(1) Mouth wash. Saline + carbolic. (2) ~~Not formed~~ – to Antipyllo to left side. B.D. (3) Haemorrhoid Suppository. 8.0.S.	S/B Full
15/5.	Left side of face incised under local anesthetic. Small amt of blood-stained pus evacuated. Small drainage tube inserted. Condition fair.		
16/5.	T. 100.6 P. 96. Pain over right face – V. L. evidence of pus. Left side discharging freely – Dressing apparently unchanged. over night. Local fair only. Drinking fairly well.	1. Dr. Dressing to left side. lotio changed as often as req. 2. Saline + Carbolic mouth wash. Q2H.	

Great care is to be taken to make sure Mrs. Subbay's mouth is clean after having taken food giving her a mouth wash is insufficient – Inspection is necessary.

"/5 W24m 17/5 19/7 D 12[illegible]

陸軍軍医中尉 斎藤傍吉

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No			Doctor		
Unit		Nationality		Rank Name	
Disease		Date Admitted		Date Discharged	died 1.6.42

Date	Treatment	Remarks
25/4.	M. Sod Sulpha - Lab Report. Dysentery Bacillary Emulsate ++++.	
28/4	Sulphas Thiazol Tabs 8. Diet Fluids only - over 40 stools per day - Persistant Vomiting & Hiccough.	
29/4	Morphia gr 1/4. stools 8 -	
30/4	Morphia gr 1/4.	
5/5	Tr morph chlorof. ℥xL at night. as necessary.	
2/5	Bismuth. daily. Persistent vomiting & hiccough	
6/5.	Lab Rept. Stool No Bacillary Emulsate	
9/5.	Morphia gr 1/4. Stools 9.	
	Daily mouth & Throat paint. Ulcerated lips, tongue & pharynx. Taking very little nourishment.	
16/5.	Diet only Lab Rept Stool No Bacillary emulsate.	
17/5	Slight mucus in stool. Refused all food.	
18/5	Subcutaneous Saline Lab Rept Stool No Emulsate & Diet. Taking no nourishment - Spoon Feeding.	
19/5	Sub cutaneous Saline	
20/5	Sub cutaneous Saline.	

Died 5 am. on 21/5/42

D. Strahan
Capt. I.M.S.

Edmonstone
Major I.M.S.
3rd P.W.H

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85:88

NO. 2 HOSPITAL.

POST MORTEM - Pte.G. PETTENGELL.

External Appearance:- Thin, but not emaciated. P.M. lividity present, no rigor mortis. No edema. Large bedsore about 2 cm. in diameter over sacrum.

Chest.

(1) Lungs. Pleural cavities normal - no fluid or adhesions. Lungs showed some terminal congestion only.

(2) Heart. Slight increase in pericardial fluid. Heart slightly increased in size. No clotting of blood. Right ventricle very thin, Left Auricle normal. Mitral valve shows old cartilaginous scaring of valve cusps. Poor musculature Left ventricle. Coronary arteries O.K. Aorta appears normal.

Abdomen.

Liver, Spleen, Kidneys, Bladder appeared normal. No excess fluid and no evidence of peritonitis.

Intestine. Duodenum contained some mucus and occasional small haemorrhagic areas. Normal colour and texture.

Beginning about half way along the ileum there were haemorrhagic patches with discoloration of the tissue. No thickening or ulceration. About 2 - 3 feet from caecum this became intense and gut wall became slightly thickened. The internal surface was dry in appearance- not shiny, - rough and had lost normal structure. There were no ulcers but the whole surface was dotted with small warty growths. The whole resembled a toad's skin. Numerous bleeding points present. There was increased thickening toward the anus.

Head.

Not examined.

Cause of death.

1. Chronic Entero-colitis.
2. Myocardial failure.

Surgeon Lt.Commander. R.N.

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05/09

入院番号 NO	診断軍医名 NAME OF DIAGNOSING DOCTOR	Sinn			
部隊号 UNIT D.D.C.	国籍 NATIONALITY Br.	階級氏名 RANK AND NAME PTE. G. PETTENGELL.			
病名 DISEASE Diarrhoea: Enteritis. colitis.	入院日 DATE ADMITTED 15/5/42	退院日 DATE DISCHARGED Died 23/5/42			

月日 DATE	TREATMENT 治療方		輸送区分	摘要 REMARK
	Diarrhoea. 24 hours. Pain, tenesmus. No blood. Anuresis. Mouth v. dry. Headache ± - Vomited several times. No cough. No pneu. Listless.			
	O/E. Tongue dry & cracked. Abd. painful - espec. over course of colon. V. weak.			
	(1) Sod Sulph ʒii Q.2H 4 doses.		S/B	Water only ad lib. No food
16/5.	Bowels open frequently. Small amt of bile fluid, no blood or mucus.	(2) Linct. Opii et Belladonnæ ʒi ÷. Stat.	S/B	Water. No food
16/5.	T. 102. Delirious. Bowels open a number of times, ē incontinence. Fluid only.	(3) Mist XV's. ? ʒi ÷ Stat & repeat 8.0.S.	S/B	Fluids. ++++.
17/5.	T. 100° P. 100. Abd v. sore & tender. Motions. Still v. dehydrated. E.T. 98°. P. 88. B.O. ++.	(1) repeat. ʒii hourly for 2 doses.	S/B	Fluids
		(3) N.S.	S/B	Waters only
18/5.	Pulse. V. rapid. Continuous diarrhoea during night. V. dehydrated. Abd. pain less. Mot B+M. present in stool a.m. today.	(1) Linct Opii & Belladonna T.D.S.	S/B	Waters only. 8 pints.

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00191

DATE	TREATMENT	害物法律病 要注意 REMARK
19/5:	Admitted.	
20/5:	Same night slight rise. Temp. only raised this a.m. Sore throat & Membrane present.	(1) B.D. d/d Pain.
21/5:	Slept fairly well. Temp. same. Throat less sore & membrane.	② Tinct opii v Minims d/d ℞ TABS.
22/5:	Complains of pain in throat. Temp. 101°. Membrane clear.	(1) Mistura Salina. T.D.S. (6-8m) (2) Pulv. Kv. Bd.
23/5:	Throat painful. Temp. 100°. Membrane clear.	Patient complains of pain in throat. Temp. & pulse normal.

Discharged at own request.

Signature.

陸軍軍醫中將 齋藤俊吉

NO. 2 HOSPITAL.

POST MORTEM - L/Cpl. H.F. FERRINGTON, Midd.

...

External Appearance:- Wasted, no external edema, P.M. lividity present, several small sores over sacrum. Much fluid from nose and mouth. Rigor mortis present.

Chest.

(1) Lungs. Pleural cavities contained about 150 c.c. of blood-stained fluid each. No adhesions. There was basal congestion in both lungs, which were waterlogged. Small amount of pus expressed from bronchi in right lower lobe.

Mediastinal glands normal.

(2) Heart. Pericardium normal - small amount of fluid. Myocardium flabby - diastole. The Right Ventricle, thin and pale - p.m. clot present. Left Ventricle edematous and pale. Valves normal. No evidence of past disease.

Abdomen.

Liver - section showed some evidence of degeneration. Gall bladder normal.

Spleen - small and contracted.

Kidneys -Left normal.

Right - small amount of pustular fluid in pelvis.

Bladder - N.A.D.

Pancreas - Dark and slightly blood stained.

Stomach - Several large haemorrhagic areas scattered over fundus of this organ.

Intestines - Small scattered haemorrhages in duodenum, ileum and colon.

The sigmoid colon (terminal end) and rectum showed a number of old healed punched out transverse ulcers.

Head.

Not examined.

Cause of death:- Myocardial failure due to malnutrition secondary to Entero-colitis and Gastritis.

Surgeon Lt.Comdr. R.N.

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29.08

入院番号 VO	No 126	診断軍医名 NAME OF DIAGNOSING DOCTOR		Lt.Cdr. W.D. Gunn	
部隊号 UNIT	Middlesex.	國籍 NATIONALITY	Br	階級氏名 RANK AND NAME	L/cpl. FARRINGTON. HERBERT. F.
病名 DISEASE	1. Malnutrition 2. Chronic Enteritis.	入院月日 DATE ADMITTED	13/5/42	退院月日 DATE Died DISCHARGED	26/5/42

月日 DATE	診方 TREATMENT	輸送区分	摘要 REMARK
	Had Dysentery in N.P. about 3/1/42. Was in Bowen Rd. for 3 mos. Does not know what type. Had Fever, was passing blood & mucus. Had relapse in C/Boo about 8 days after leaving. B. Rd & went to Argyle St. Was not quite well. but felt fit enough to go back to camp. Began about 2 weeks. diarrhoea - no blood or mucus at all. Diarrhoea is gradually improving. , B.O. ↑ (24 hr) loose - but no blood or mucus. Has pain all over abdomen, intermittent, pain is worst just prior to defaecation, pain is worst after bread meat rice. Comes on about ½ hour after food. Has been vomiting during last 48 hours, after food. States he brought up some "black muck" ? Blood - no bright blood. Slept quite well - v. thirsty all the time. Passing water O.K. No headache.		
	Malaria:- 2 years ago.		
	O.E. V. Emaciated. Sl. distress.		
	Mouth:- Tongue v. red - smooth + sl. swollen clean.		
	Chest Movements fair. No rales etc.		
	Heart B.C.D. small - sounds poor quality. Pulse fair volume No pulsation of neck veins in erect or recumbent. no edema.		
	Abdomen:- Emphysema - Vaguely tender all over & guarding over course of colon. No masses. Most tender over descending colon & pelvic colon.		

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[redacted] Tennington.

DATE	TREATMENT			
14/5/42.	V. weak. vomited soup & sleeping draughts. Slept poorly. Pulse fair only.	(1) Glucose ʒi T.D.S. (2) Chlorid + Brom aa gtsXX N.S. (3) Vit. B. biscuit 1. daily. (4) Vit. B. tabs. 6. each ē each meal. (5) 2 Eggs.	S/B.	Fluids ē toast. Small feeds 2H.
15/5/42	Pulse fair. taking food + fluids better. Slept better. incontinent once. Pain in abdomen	(1) Glucose ʒii T.D.S. (2) Chlorid + Brom aa gtsXV N.S. (3) Vit. B, biscuit. 1 daily (4) Vit B. tabs. 4 ē each meal.	S/B.	Fluids ē toast.
16/5.	Sl. improved. No vomiting. incontinent once. Pain v. severe lower. over left lower zone- Colonic colon	(1) - (2) - (3) - (4) (5) Colonic Saline wash-out. B.D.	S/B	Fluids ē Toast.
17/5.		1 - 2 - 3 - 4 - 5.	—	—
18/5.	Slept better, some diarrhoea but pain less. looks better	1 - 2 - 3 - 4 - 5.	S/B	Fluids ē Toast. Small amt of meat at lunch
19/5.	N/c B.O. 6 times during night	1. 2. 3. 4.	—	
20/5.	Improved. generally appetite better pain less.	(1) - (2) - (3) - (4)	S/B	Fluids, bread meat - spares vegetables
22/5.	Has incontinence + diarrhoea now. eating better. + looks better. Marked tenderness over caecum + descending colon.	(1) (2) (3) - (4) - (5). 1. Thiamin ½ t.c. daily 2. Nec. dil Mixx Q.v.H. 3. Vit. c. tabs ii daily. (4) Mist 3 Kj's N.S. Smaller sips of fluid by mouth only * ATTENTION. MOUTH HYGIENE.	S/B	—
25/5	B.O.T. Pulse good. Slept v. well. Vomited once. Received 950 c.c. glucose saline ē some fluid by mouth	1. 2. 3. 4. S.O.S.	S/B	Sips of fluid only
26/5.	Vomited during night. E.T. 102. V. well + up today.	Pulse fair but is not. (1) ½ c.c. every 3rd day S/B (2) Vit. C. tabs. i B.D. (3) Rectal Saline B.D.		Milk + glucose prn

Collapsed + Died at 1630

26/5 [illegible]

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00184

No	7285		NAME of DIAGNOSING DOCTOR		Captain, T. P. SUNDRAM I.M.S.
UNIT	577 R.A.	NATIONALITY	INDIAN.	RANK NAME	HAV. PURAN SINGH.
NAME OF DISEASE	DYSENTERY. + (Bacillary Etiology) CHRONIC GONORRHOEA.	DATE ADMITTED	5.5.42.	DATE DISCHARGED	DIED 24.5.42 D & E D. 24.5.42.

DATE	TREATMENT	REMARKS
5.5.42.	MIST SALINE - 3i, 6 TIMES.	
6.5.42.	MIST SALINE - 3i, 4 TIMES.	
7.5.42.	MIST SALINE - 3i, 3 TIMES.	
8.5.42.	MIST CHLOROFORM ET MORPHINE co - 3i AT H.S.	
9.5.42.	MIST CASTOR OIL - 3i, B.D.	
12.5.42.	MIST CHLOROFORM ET MORPHINE co - 3i AT H.S.	
19.5.42.	MIST ALKALINE - 3i, T.D.S.	Patient Transferred to ~~[illegible]~~ V.D. side.
20.5.42.	MIST ALKALINE - 3i, T.D.S.	
22.5.42.	Tr. ~~Pentac~~ m ~~[illegible]~~. In Water td.	
23.5.42.	NORMAL SALINE - Oi, SUBCUTANEOUSLY. QUININE BIHYDROCHLORE - GR 7½. I.M. SUGAR WATER - BY MOUTH. COLD SPONGING. CAMPHORE IN OIL - 1cc (sc)	pt is very toxic, temp - 105°F + Unconscious. CONMITION HOPELESS
24.5.42.	PT EXPIRED AT ~~[illegible]~~ 9.00 A.M. Lumbl. EXPIRED AT 9.00 A.M.	

Capt Lord

Lieutenant-Colonel
MEDICAL - I.M.S.
Comdg. 3RD. P.W.H

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CASE No. 263.

No	19090		Name of diagnosing Doctor		Captain B.J. EVANS IMS.
Unit	2/14th P.R. Regt.	Nationality	INDIAN	Rank & Name	Sepoy NIRANJAN SINGH
Nature of Disease	Pneumonia Lobar both bases. ? Malaria Quartan.	Date admitted	11.4.42	Date discharged	Died on 24.5.42 at 1.45 P.M. DIED AT 1.45 P.M.

Age 2229
Service 2½

Treatment

11.4.42	Mist expect Stem ℥j Tds MB. 693 tabs = 4+2+2+2 at 4 hours intervals Total given = 10.	
12.4.42	Mist expect Stem ℥j Tds. M.B 693 tabs 2. Tds.	Improvement Satisfactory.
14.4.42	Mist expect Stem ℥j Tds	— 1. —
15.4.42	Cod liver oil ℥j Tds. Mist expect Stem ℥j Tds	
9.5.42	Mist Quinine ℥j Tds	Fever both lungs and Liver & Conditions has flared up again. Blood film shows Quartan Gametocytes.
11.5.42	Quinine Dihydrochl 10 gr I.M.	
12.5.42	Quinine Dihydrochl 10 gr I.M. Mist expect Stem ℥j Tds. MB 693 tabs 4+2+2+2+2 at 4 hours intervals given Total = 12.	
13.5.42	Camphor in oil 1 cc subcutaneously Mist expect Stem ℥j Tds. Cont Phthysis. Left basally on chest.	No improvement.
14.5.42	— do —	— 1. —
15.5.42	— do —	Response poor. Signs of basal pulmonary lesions become apparent.
16.5.42	Mist expect Stem ℥j Tds.	
19.5.42	Mist Quinine ℥j omni mane Thiamine ¾ cc IM Mist Calcium Lactate BD	
22.5.42	— do + {Tinct Digitalis ♏ X} Tds {Mist expect Stem ℥j}	

PTO

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98:08

Continued.

23.5.42. General Condition hopeless.
Pulse weak and fluttering.
Patient becomes occasionally delerious & mutters that

Camphor in oil 1cc 8c
Tinct Digitalis - ♏X TDS
Mist. expect Alum ʒj TDS
Mist. Quinine ʒj once in the evening.

24.5.42 Patient (occasionally vomiting) Condition Lightly hopeless today
He is delerious; has passed motions and urine in Clothes.
Keeps his head rather Stiff.
Cerebro Spinal fluid aspirated 3 ccs
No Turbidity in fluid
fluid Clear.

Tinct Digitalis ♏X TDS
Mist expect Alum ʒj TDS

12 A.M. Patient has passed out of bed.
Special Sick attendants provided for proper service.

1.45 P.M. It is regretted that the patient breathed his last at 1.45 P.M and died of heart failure.

B. Jeffreys,
Captain I.M.S.

DIED AT 1.45 P.M.

Commanding

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No	20482		NAME OF DIAGNOSING DOCTOR		Captain B.I. EVANS IMS
UNIT	5/7th RR	NATIONALITY	INDIAN	RANK NAME	Sepoy RAM SINGH.
NAME OF DISEASE	I ANKYLOSTOMIASIS II Secondary Anaemia III Pneumonia Lobular	DATE ADMITTED	30.4.42.	DATE DISCHARGED	Died at 6.55 P.M. DIED 26.5.42

DATE	TREATMENT	REMARKS
30.4.42.	Mist Ferri et Ammon Cit ʒj Tds.	Marked prolonged Anaemia palpitation and swelling of feet and ankles. Bowels on motion loss of three pints + loss of sensation in feet + ankles. Haemic murmurs ++.
1.5.42	Thiamine ½cc Subcutaneously.	
9.5.42	Mist Sodae Salicylat ʒj Tds	
12.5.42	Rp Carbon Tetrachlor ʒj 40 / Ol Chenopodium ʒj 20 / Castor Oil ʒj — followed by Mist Salinae ʒj 3 hours later.	
13.5.42	Mist Ferri et Ammon Cit ʒj Tds.	
16.5.42	Mist Quininae ʒj Tds.	
19.5.42	Mist Expect Sed ʒj Tds	Begins of Convalescence in Lungs.
22.5.42	Rp Carbon Tetrachlor ʒj 40 / Ol Chenopodium ʒj 20 / Castor Oil ʒj — followed by Mist Salinae ʒj at 12 A.M. +	
24.5.42		
25.5.42	Patients' Condition Hopeless. Mist Expect Plain ʒj Tds. Sponging Tds. Pared Nails & Hair in Cloths & Carbolic Solution & Syringing Ears with Creasote 1 in 20.	
26.5.42	Condition Hopeless. Mist 10 gr gum Died at 6.55 P.M.	

Lt Col IMS
Officer Commanding No 3 P.H. Unit Jhansi

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89168

No	15890		NAME OF DIAGNOSING DOCTOR		Captain B.J. EVANS IMS.
UNIT	3/7th RR.	NATIONALITY	INDIAN	RANK NAME	Subdy SIRI RAM SINGH
NAME OF DISEASE	Dysentery Bacillary. Enteritis	DATE ADMITTED	2.5.42	DATE DISCHARGED	Died at 8.35 PM on 28.5.42

DATE	TREATMENT	REMARKS
2.5.42	Mist Salin 3ji 8hrly Mist Ferri Ammon cit 3ss TDS	
3.5.42	Mist Salin 3ii 4hrly hrm for 6 drns.	
5.5.42	— " — + Thiamine 1/4ce subcutaneously	
26.5.42	Mist Salin 3ii 4hrly hrm for 6 drns.	
22.5.42	Codein sul gr 5 TDS	
25.5.42	Emetine Hcl 8c.	
27.5.42	Mist Chlorpm et Morph (gr X) BD	Signs of Heart failure ++. Left oedema of feet. Patient is unconscious Passed Motions in Clothes. Pulse good + thready.
28.5.42	Tinct Digitalis gr XV at 11AM, 5PM	

6.30 PM.

Patient's Condition is Hopeless. He is moaning unconsciously
Pulse extremely feeble and weak
Respiration - Hurried. Inspiration forced
eyeballs pulled up

It is regretted that the patient died from Heart failure at 8.35 PM. 28/5/42.

B.J. Evans Captain IMS.

Certified true copy
Major
Comdg No. 3 Pay Co. Hqtrs

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NO. 2 HOSPITAL

POST MORTEM - Pte. LAWRENCE, John Henry

External Appearance:- Male of about stated age. No marks or scars. Rigor Mortis. P.M. lividity present. No external wounds or evidence of injury.

Internal Examination:- Small amount of subcutaneous fat. Masculature fair.

Head:-
Cranial bones very thin. There was abnormal quantity of C.S. fluid. Vessels in pia and over surface of brain very injected. There were a few sub-dural adhesions about origin of nerves VII and VIII. No evidence of recent disease, haemorrhage, etc.

Chest:-
No pneumothorax.

Left lung- Pleural cavity dry, no adhesions. All lobes of lung were congested and bronchi filled with frothy fluid. No evidence of tuberculous infection.

Right Lung -About 200 c.c. clear straw coloured fluid in pleural cavity. Upper lobe congested, firm and had large area of red hepatisation involving the antero-lateral half. There was a bulla about 1 by 2 cm. at apex. Middle lobe slightly congested. Lower lobe congested. Bronchi full of fluid. No pus could be expressed. No evidence of gross tuberculous lesions.
The surface of both lungs were studded with small sub-pleural whitish areas about size of sago grain. No evidence of caseation on section.
Mediastinal glands normal in size, etc.

Heart:-
Slight excess fluid in pericardial space. Heart enlarged flabby and in diastole. Right ventricle dilated, tricuspid and pulmonary valves normal. Left ventricular wall thin and pale. There was thickening of free border of mitral valve - probably old endocarditis. Aortic valve admitted one finger with ease. No evidence of disease. First part of aorta and coronary arteries appeared normal. No scars present.

Abdomen:-
Large amount of clear, yellow brown fluid in peritoneal cavity.

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Post Mortem - Pte. Lawrence (cont)

Abdomen (cont)

(1) Spleen - very enlarged; abour four times normal size. Section interior very soft and fluid. Capsule stretched but stripped easily.

(2) Liver - pale yellow colour with a number of old healed scars on the surface. Section showed loss of normal lobulation, the whole appearing very firm and meaty. The bile ducts exuded thick light yellow bile. Capsule stripped easily in some areas only. No parasites seen. The gall bladder was long and narrow and cystic duct suggested dilatation. Wall not thickened and no stones palpated.

(3) Kidneys - Slightly congested but otherwise normal. Adrenals appeared normal. Bladder normal.

(4) Pancreas - small normal consistency.

(5) Stomach large, intestines showed no thickening or external evidence of disease.

Smears taken from spleen, blood in anterior communicating artery of Circle of Willis. Smears of fluid in lungs and bile also made. Nothing abnormal seen.

Cause of Death=-

(1) Myocardial failure due to Chronic Malaria.

(2) Right upper lobe Pneumonia.

Surg.Lt.Comdr. R.N.

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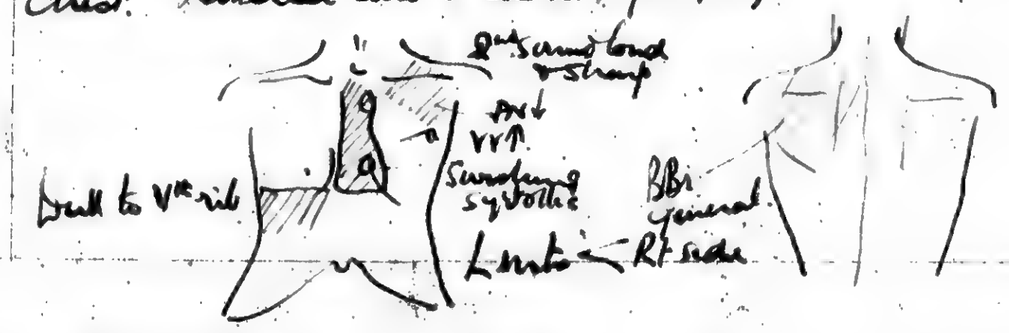
入院番号 NO	No 160	診断官署名 NAMA OF DIAGNOSING DOCTOR	Sing Lt RA Jackson MVR
部隊号 UNIT	HQ HRVDC.	国籍 NATIONALITY	階級氏名 RANK AND NAME — Pte LAWRENCE John Henry
病名 DISEASE	(1) Malaria (M.T.) (2) Pulmonary. T.B.	入院月日 DATE ADMITTED — 21/5/42	退院月日 DATE DISCHARGED — Died. 3.20 am 29/5/42.

月日 DATE	治方 TREATMENT	摘要 REMARK
	Rx (1) Quinine bi hydrochloride I.M. 10 grs.	Hinds +++
	Co. Weakness Shortness Br. Fever. (2) Quinine bi hydrochloride 8 gr 5 grds.	Stret/Bed
21/5/42. H.P.C.	3 wks Legs weak, fever vomiting, breathlessness Semi formed motions B.O. ° Abdominal pain Admitted camp hospital, discharged after ° 20 days Stronger but still feeling sick 2 days ago Readmitted ō high ° fever said to be 105°	
PH	Tonsillectomy as child. Severe M.T. Malaria 7 yrs ago. associated ō Orthopnoea ? clams in rt. groin. Recurrent malaria since but attacks becoming fewer at less frequent intervals. — Always took Quinine but has had both. Albumin ? Plasmo-Grains 3 Kyps. G.C. infection	
Occupation.	Storekeeper takes fairly active exercise and except for Malaria was considered fit	
FH.	2 b/s. F 84 b/s. M 15. d. Rh. Fever 15 b/s	
CNS	Dull. memory only ē effort, sleeps poorly but on shutting eyes hallucinations of people talking, clutching in air, and giddiness	
RS	Sh Brs. only associated ē fever. Slight cough, rare sputum. ° Night sweats CN - Palpitations +	
GU ✓	GI. Tenderness of Abdomen	
COA	Dull apathetic individual, appears blue about lips ō palpable visible pulsation in neck trachea central warm good colour. Tongue clean, furred fetor.	
Chest:	Flattened and ō costal splaying	



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DATE	TREATMENT	REMARKS

22/5. 23/5. **Heart.** Pulse weak, and regular ACDNE. Mist. Sedativa 3/s nocte
Blowing systolic replaces 1st. interval to mitral area not conducted. Apex beat 11ins at P. area.

Abdomen Prominent & sagging of costal borders

Limbs. Evidence of clubbing of both fingers & toes.

Sputum: A few bacilli having the morphological appearance of A.C.B. seen.

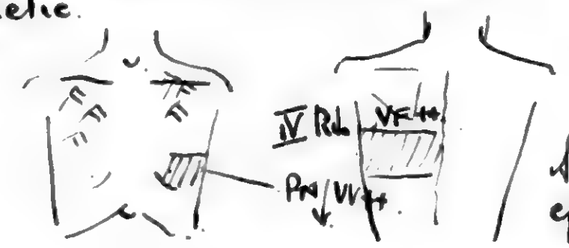
Urine: Highly conc.d otherwise N.A.D.

Stool. Meagre, chocolate coloured fluid, containing large numbers of motile organisms and leucocytes.

Blood. Smear for M.P. none seen.
Thick drop – A few Subtertian rings & crescents seen.

25/5. **Throat.** Sorethroat, – Granular pharyngitis & tonsils. Tongue dirty. General condition improved.

27/5. Very dull, complaining and apathetic.



Phenol Cough 2% in hot water.
Senn. Solid diet
One E87.
2 Bottles milk daily.
Bread. Ounces.

Marked abdominal shifting dullness.
Muscle tone poor.

28/5. **Throat.** Weakness + pins and needles in his legs. – Motor function poor. – Miserable and whining – talks a lot in his sleep.
Pleasure much better. Sputum. – No A.C.B. in 2 Specimens seen.

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月日 DATE	治方 TREATMENT	摘要 REMARK
28/5.	Seized with attack of acute dyspnoea, Cyanosis ++ Temp 100 acute anxiety. Pulse at wrist about 140/min Laryngeal hysteria. — Infection Whoop. Pneumonia.	
29/5.	Sleeping peacefully with shallow respiration at 2.30 am. — Died 3.20 am.	Prontosil. 3/5. 5/5.
29/5	昭和14年5月29日午前3時20分死亡	C. Jackson

陸軍軍醫中尉 齊藤俊吉

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No. 10723

Name & designation of Doctor: Captain B.J. EVANS. IMS

Age: 33 Sex: M

Unit: 5/7th RR.

Nationality: INDIAN

Rank & Name: Sepoy HEM SINGH

Disease: Dysentery Bacillary Ex. & Malaria M.T.

Date admitted: 12.5.42

Date discharged: Died at 3.30 AM on 31.5.42

Date | Treatment | Remarks

13.5.42 Mist sod bicarb Stim } 8th Tds.
et Sulph alba }

16.5.42 Mist Quinine 8th Tds.
Thiamine 1/4cc subcutaneously.

19.5.42 Thiamine 1/4cc
Mist Quinine 8th BD

Malarial attacks M.T. Recpt.

28.5.42 Thiamine 1/4cc
Cultures taken on BD.

29.5.42 Rp Bismuth Subnit — 15 gr
Tinct chloroform Et Morph Co. 3 V
Ipecacuanha — 0 8
Opium — 1/2 gr. } Tds

Frequent motions last 24 hours. Patient sleeps a little. No complaint on opthecha.

30.5.42 Patient Comatose. Stools uncontrollable
Signs of Heart failure + +.
Mucus Still present in Stools.
Doctor with Theraby
Champhor in ice spoon.
Tank milk

31.5.42 It is regretted that the patient died at 3.30 AM.

B. for Evans Captain IMS

Thompson
MAJOR. I.M.S
3RD. P.W.H.

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入院番号 NO	No 183	診断軍医名 NAME OF DIAGNOSING DOCTOR			
部隊号 UNIT	D.D.C.	國籍 NATIONALITY	Br.	階級氏名 RANK AND NAME	Pte. ARTHUR FRANCIS JENNINGS.
病名 DISEASE	① Acute Enteritis. ② Myocardial Failure.	入院月日 DATE ADMITTED	2.6.42.	退院月日 DATE DISCHARGED	3.6.42. Dean.

月日 DATE　　TREATMENT 治療方

輸送区分　摘要 REMARK

This man went sick 3 days ago & acute diarrhoea and abdominal pain. The pain has eased considerably but acute diarrhoea persists. B.O. about XXX times in 24 hours. He has not vomited.

O/E.

T. 100.2　P. ~~120~~ 128　Tongue v. furred: dry.
abdomen. generalised tenderness.
Shocked - hands cold & pulse very ~~weak~~ poor.
Heart Sounds v. poor. Dec-tach - pulse regular.
No evidence of free fluid.

Patient's condition rapidly deteriorated, pulse poor & at times almost imperceptible. He was completely irrational and unable to retain rectal saline.

(1) Rectal Saline.
(2) Mist 3 A.V.'o N.S.

3.6.42　Patient died at 0650.

3/6　[illegible]

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入院番号 NO	No 151	診断官氏名 NAME OF DIAGNOSING DOCTOR	Gunn
部隊号 UNIT	R.A. 92 Coast Battery	國籍 NATIONALITY	Br.
病名 DISEASE	Dysentery. Bacillary.	入院日日 DATE ADMITTED	25/5/42.
階級氏名 RANK AND NAME	Bomb/R. ROGERS, Joseph	退院日日 DATE DISCHARGED	Died 9/6/42

月日 DATE	治療 TREATMENT		摘要 REMARK	
	Diarrhoea began about 4 days ago. Severe pain. Vomited once only. Passing blood + mucus + bn numerous times. No Headache.			
	No past history of Dysentery.			
	No other complaints.			
	O/E. Tongue furred. Generalised Abd. pain.			
24/5.	B.O. +++. now beginning to ease + less pain. No sleep during night	1. Tinct. Opii + ~~Belladonna~~ M.S.	S/B.	Water. Fluids. No Food
		(1) Soda Sulph. 3ii Q 1H 4 doses	—	
		(2) Mist. 3 XV ad M.S.		
25/5	B.O. XIV pain much less. Has not slept	N.T.	S/B	Fluids.
		Repeat. (2)	—	Fluids
		Repeat (1) at 6 a.m.		
26/5.	No change v. weak. No sleep. B.O. ++. Stool. Faecal colour - looking No blood or mucus.	(1) Tinct. Opii et Belladonna ~~T.D.S.~~ from ~~#~~ 3ii M.S.		
		(2). pim. Q 6H.		
27/5	much better	N.T	S/B	Thinned Full Notice
28/5	T. 101. - P. rapid. Less faeces much diarrhoea, no blood or mucus.	(2) ~~5~~ T.D.S.	S/B	Fluids.

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Rogers.

月日 DATE	治方 TREATMENT		摘要 REMARKS	
1/6.	V. drowsy weak. Abd v. soft.	(1) Special mixture. Q 4 H.	S/B	Fluids ad lib
2/6	Had 15 grs. ortal last night. Bowels open many times. Had some sleep. Pulse rapid, fair, heart poor.	(1) ℞ Mist 3 XV's. Q 4 H. pm.	S/B.	Fluids. ad lib.
3/6.	Improved sl. Slept better Do. less often some blood.	(1).	S/B	Fluids.
4/6	Improving still low fever 100 + P.R. 100.	(1)	S/B	Fluids. & Mince.
5/6	E.T. 101. 100.8 / 110. 120 - B.O. iii Has few rhonchi + large mucous rhles at left base.	(1) Sulphaguanidine 4 stat & 2T Q 4 H. (2) Pot. Brom & Chloral ē Asp. grs X V. N.S.	S/B	—
6/6.	V. weak. & dehydrated. Tongue furred. B.O. 1800 Rectal haemorrhage - large clots etc. Partly destroyed	(2) H.S. ℞ Hot Rectals wash out 2. Coagulen 1 c.c. 3. Morphia grs 1/3 } Stat 2. may be repeated in 2 hrs	S/B —	Fluids & mince. Stop all fluids by mouth
7/6	Restless well. T. still sup. Pulse is strong but rapid. More blood.	ABSOLUTE REST. (1) Coagulen. 1.8 c.c. ~~3 c.c.~~. ℞ No fluids by mouth. May wash out mouth ē Coldwater. 1. Morphia grs 1/4 Stat & repeat at 2 p.m.	—	

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80179

座下軍醫中將 齊藤俊吉

座下軍醫中將 齊藤俊吉

昭和17年6月9日

2・昭ヲの3北ニ2

座下軍醫中將 齊藤俊吉

9/6 Flesh v. nephr. - not so chronic cases as dilation - v. daily doses. B.N.O chronic cases bad. 15,200.
① Hospital Ships
Fluid. 2oz w.hrly max.
Gum 3oz.c. dextrin mixture
see Supplementary
June 2nd 1916

8/6. Has no temp bus. B.N.O for 12 hrs. Morning afternoon cases of disease - a. mucus effusion. Pulse fair enough. Abdominal pt. Class appears clear.
1. Morphia gr ¼ Quit him.
2. Temperature 1.1.c.c. Quite T.D.S.
Keep quiet and 2 glasses hot water

NOTE TREATMENT

Post Mortem - Bdr. Rodgers, Joseph (cont)

(6) Stomach & Intestines (cont)

abdominal wall which was injected. Gentle separation disclosed two perforations of gut wall in this position. The stomach and small intestine as far as the terminal ileum appeared normal, except for bile stained mucus membrane. The last 12 inches of ileum were injected, ulcerated and discoloured. The ulcers were shallow and transverse, and increased in number toward the caecum.

The ascending colon was discoloured, ulcerated and slightly thickened. The Colon, from the hepatic flexure on, was exceedingly friable, so much so that movement of omentum tore open the whole transverse colon. The tube wall was slightly thickened - mucosal surface bluish black and covered with large transverse ulcerations. These were deep and in places had perforated all coats except the serosa. The bowel wall resembled a more or less regular lattice work.

Cause of Death:-

(1) Acute Peritonitis following perforation of sigmoid colon caused by acute bacillary dysentery.

(2) Myocardial Failure due to Toxaemia.

Surgeon Lieut. Comdr., R.N.

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08/00

10/6/42.

NO. 2 HOSPITAL

POST MORTEM - Bdr. ROLGERS, Joseph

External Appearance:- Partially edentulous. Small saucer shaped sore over lower lumbar region about 1 c.m. in diameter. Small transverse incision right antecubital fossa, closed with 3 stitches. Pink frothy fluid exuding from mouth and abdomen grossly distended. No edema. Rigor mortis and P.M. lividity present.

Internal Examination:-

Cranium:-
Not examined.

Chest:-

(1) Lungs - No free fluid in plural cavities. Both lungs very congested, right more than left. Old healed tuberculous scar at right apex. Right lung attached to the parieties by numerous adhesions. No evidence of pneumonia.

(2) Heart - Pericardium normal. Heart fatty and in diastole. Ventricular walls thin. Thickened aortic cusps. No evidence of atheromatous changes. Coronaries clear.

Abdomen:-
Much subcutaneous fat. Perforation of peritoneum allowed the escape of much gas. Increase of fluid which was thick, grey brown in character.

(1) Liver - Smaller than average. Section showed some fatty change. Gall bladder distended. No stones.
(2) Spleen - Normal size - soft, wrinkled. Section dark and rather spongy.
(3) Kidneys - normal. Small cyst in lower pole of right kidney.
(4) Bladder- normal. Some urine present.
(5) Pancreas - normal.
(6) Stomach and Intestines - The intestines in the lower abdomen and pelvis were matted together by soft very recent adhesions and lymph. The sigmoid colon at the brim of the pelvis was loosely attached to the antero-lateral

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Case No. 88

No	12	NAME OF DIAGNOSING DOCTOR	Capt. T. P. SUNDRAM I.M.S
	CIVILIAN	NATIONALITY: INDIAN	RANK AND NAME: WATCHMAN THAKUR SINGH age 55 years
DISEASE	TUBERCULOSIS GLANDULAR BOTH GROINS	DATE ADMITTED: 1. 3. 42	DATE DISCHARGED: 15. 6. 42 DIED

DATE	TREATMENT	REMARKS
1. 3. 42	Patient admitted with suppurating inguinal glands which were scraped; Dressed with sulphon powder.	
4. 3. 42	No improvement with this line of treatment	
10. 3. 42	Sinuses scraped again and dressed with acriflavine - Dressings to be continued for one week.	
17. 3. 42	No improvement of wounds. Still discharging and glands still suppurating.	
18. 3. 42	Dressing changed to sulphon powder dressings daily.	
20. 3. 42	Tab. magn. sulphate 30 grs. given as purgative with satisfactory result.	
24. 3. 42	Condition not improving. Patient getting thinner.	
30. 3. 42	Wet Septic Dressings to be applied daily.	
1. 4. 42	Dressings continued. No improvement.	
7. 4. 42	Tab. ½ tri grs daily to be given for 1 week. Condition slowly getting worse.	
14. 4. 42	No improvement of the condition - daily dressing continued	
21. 4. 42	Sinuses still discharging. Patient has a cough but no definite sputum.	
15. 5. 42	Tubercle bacilli found in large numbers in discharge from Patient's sinuses. Dressings continued	
20. 5. 42	Condition getting worse. Dressing continued	
25. 5. 42	Gradual weakening of Patient - daily dressing	
3. 6. 42	Patient very weak. Wound not healthy at all - much discharge	
7. 6. 42	Patient much worse - foul discharge from wound. Dressed daily	
14. 6. 42	Condition of Patient very low	
15. 6. 42	Patient died at 6.10 p.m.	

Chemist's duty made by
Comdg. Officer Prisoners of War Hospital

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Case No: 412 Diagnosis Record (One for each patient)

入院番号 No.	5685		診断軍医名 Name of diagnosing doctor	Captain F. P. O Sundram Ind.	
収容部隊名 Unit	5/7 Rajputs	国籍 Nationality	Indian	階級 Rank 氏名 Name	RAM BUX SINGH
病名 Name of Disease	PNEUMONIA LOBAR ACUTE BOTH LUNGS	入院月日 Date admitted	19.6.42	退院月日 Date discharged	DIED 19.6.42

月日 Date	治方 Treatment	輸送区分	摘要 Remark
19.6.42	Patient arrived at the hospital at 3.25 p.m. in an extremely bad state. Condition very low & feeble pulse. Both lungs were affected - the right lung being completely consolidated. Passing stools in clothing. In spite of all available medical aid the patient died at 7.10 p.m.		

Lieut Col Thomas
Major Dy
Comdg No: 3 Pleasure Ship Hospital

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E81 08

NO. 2 HOSPITAL

POST MORTEM - Sapper LEMON, Ernest. R.E.

External Appearance:- Well nourished male. Left anti-cubital fossa ecchymosis from saline infusion. Left thumb second degree burn. Gross edema of penis and scrotum (see below). Numerous superficial sores over buttocks, in the anal cleft and on the medial side of thighs. Slight degree of post mortem lividity. Rigor Mortis present about 2 hours after death.

Internal Examination:- Brain not examined. Muscles well developed and fair amount of subcutaneous fat.

Chest:-

(1) Lungs - Right, marked congestion of lower and middle lobes.
Left, partial congestion of lower lobe. Nil else abnormal.

(2) Heart - Dark brown pericardial fluid, increased in amount about 50 c.c. Heart normal size. External surface showed a few scattered petechiae in muscle over ventricles and auricles. A dark haemorrhagic area about 2 c.m. in diameter was present at the base of the left ventricle about 1 c.m. from inter-ventricular septum. This had the gross appearance of a recent infarct. The endocardial surface showed numerous small haemorrhages and these extended throughout the ventricular muscle. They were most marked about the region of the infarct. The mitral valve showed thickened cusps. Other valves normal. Aorta and coronary arteries appeared normal.

Abdomen:-

No free fluid. Colon appeared dark green, an abnormal colour so soon after death.

(A) Stomach & Small intestine. Normal appearance. The colon was partially filled with clotted blood of the consistency of red currant jelly. The mucous membrane appeared to be intact, though several areas suggested haemorrhage from superficial vessels. Close examination revealed no ulceration.

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Post Mortem - Sapper Lemon, Ernest (cont)

(b) Liver. Normal in size and consistency. It had a faint icteric tinge. Gall bladder full of dark inspissated bile - no stones.

(c) Pancreas - appeared normal.

(d) Kidneys - Both kidneys appeared normal. Capsules stripped easily.

(E) Spleen - slightly enlarged, firm, toxic type.

(f) Bladder . normal, small amount of cloudy urine.

The loose skin of the penis was edematous, no evidence of any sore on corona.

The scrotum was very firm, hard and fibrous in consistency. Section through it showed a laminated appearance with haemorrhagic areas. There was no free fluid. The thickness was about 5 c.m. about the testicles which were normal in appearance. It gave the impression of a chronic fibroid swelling. There was a somewhat similar condition of the thighs where these came in contact with the scrotum. Very slight inguinal adenitis.

The history suggests that there was increased bleeding time, exemplified by ecchymosis in left elbow.

Cause of Death:-

Infarction of left ventricle leading to myocardial failure due to increased capillary permeability enhanced by the toxaemia.

Surgeon Lieut. Comdr. R.N.

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58/00

IYO. 230

LEMON. Ernest. Age 29. RES.

Rank Sqn.

Diagnosis. Cellulitis of Scrotum.

Dr Ref.

Rehj. Coll.

DATE 日付	TREATMENT 治方	DIED– 25. 6. 42	輸送区分	摘要 REMARK

Admitted 14th June

States that about 14 days ago had times of scrotum which was treated & local applications. Condition seemed to spread & about 3 or 4 days ago noticed general swelling of groin, Scrotum & penis. Has increased Considerably.

Has been very fit otherwise: No dysentry or Benikeri

Treatment: t.i.d. Radiant Heat ½ hr.
Hypertonic Saline dressings
M & B. ½ Stat. & 2 T.i.d.
Fluids +++

Vib C" tabs. 2 T.i.d.

21/6 Nil passing water. Vomiting & D.B. Repeat to

Sims 1 Occ Pronzin I.V. & 5th hrly.

22/. I.V. Trianon 10cc + & tabs Trianon t.d.s. pm. vomited the trianon tabs.

Quid ~~Radiant heat~~
Saline & dress c ½ vas 1/4 t.d. perchlor. Vib C" tabs repeated.

1 cc. V.S.G. Anti-Gas-Gangrene Serum pm

I.V. Trianon 10cc repeated pm 7.30.

23/ pm. passed the fresh blood & Stool, P. Some hard faecal matter: Morphia 1/3 & Atropin 1/100 given 4.45 pm.

Saline & water ad lib. (Conc. Saline: 1/8)
Frequent small drinks: when awake.

½ hrly turns

98/09

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LEMON. E

DATE	TREATMENT	REMARKS
24/6/42	~~No Patient~~ Patient became very weak at about 4 pm. pulse irregular — fibrillating Patient at Work in stool: ~~4 pm~~ again at 9.30 pm, but less than previously.	
25/6/42	Agn. Local condition in groin & scrotum improving but patient unconscious. marked auricular fibrillation. Saline 500 cc given at 7 am. Pulse improved slightly. Patient Died at 9 am	

昭和19年 1945 6月25日 9時40分死亡ス

陸軍軍醫中尉 齊藤俊吉

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L81 08

Case No.	—	Name of Registering Dr	CAPT. A.H.R. COOMBES. RAMC.
Unit	ROYAL ENGINEERS	Nationality	BRITISH
Name of Disease	LUDWIGS ANGINA	Date admitted	23/6/42

Rank and Name	Sapper MCMASTERS. T.
Date & hour admitted	3-35 AM. 27/6/42.

Date	Treatment		Remarks
23/6	Gargle with Pot. Permang. 1 in 5000 tds.	Up.	2 days Lucky 7 Sore throat
24/6	Swelling of throat increased Pentamidine Abscess forming Hot Saline ½ gargles tid	Bed.	Pentamidine Abscess
26/6	Bilateral "Quinsie" opened by sinus forceps Quan. Pus evacuated. Hot Saline gargles continued "Dagenan" Tabs. S. (·5 grammes) (2 every 3 hrs)	Bed	Dyspnoea Swelling ↑ neck considerable
26/6	3·30 a.m. attack ↑ Dyspnoea (acute) lasting 10 minutes Saline gargles 2 hrly. Carbolic gargles " "Dagenan" Tabs. 8 during day. ·5 grammes	Bed.	Condition improved during day Much worse in evening
27/6	3·30 AM. — Collapse. Asphyxia emergency Tracheotomy performed, Artificial respiration given in vain	Bed.	Died 3.35 AM.

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88 08

病室 No	No 236	診斷官姓名 NAMA OF DIAGNOSING DOCTOR	Sinn		
		國籍	Br.	階級氏名 RANK AND NAME	Pte. Wilson.
			27/6/42	退院日 DATE DISCHARGED	died 27/6/42.

RE.
~~Acute Tonsillitis.~~
Diphtheria.

DATE	TREATMENT	摘要 REMARK
	History - Unknown.	
	O.E. Marked swelling of neck & sub maxillary glands. Mouth only partially opened. Both tonsils & uvula covered ī muco-pus.	
	1. Tuinam. #5 Labs. Stat: & repeat IV Q4H. 2. Gargles. Carbol Saline Q2H. 3. Clean throat ī Glyc & Iodine	S/B Fluids.
1800	Looks better. T.102 P.120.	
2000	- Got out of bed. - taken back & shortly after was choking & cyanosed. Tried to vomit Artificial respiration started and Adrenaline 1/c.c. pericardially. No respiration after this	
	Died 2020.	
	~~Cause of death - 1. Asphyxia~~ ~~2. Cardiac failure~~	

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00198

W/ASON

NO. 2 HOSPITAL

POST MORTEM - Gunner WESTWOOD, Eli. R.A.

External Appearance:- Large, well nourished male. Tattoo marks both forearms - Popeye on the right and a Cross with 'Mother' on the left. The skin over the anterior wall was covered with a number of small papules; a few were scattered over his face and back. Large area over sacrum of slough. Skin in this region soggy. A number of teeth missing. Post mortem lividity present. No rigor mortis present after two hours.

Internal Examination:- Musculature good. Little subcutaneous fat.

Cranium:- The dura appeared to be slightly congested. The surface of the cerebrum and the mid brain very congested. No evidence of haemorrhage or tumor. The spinal fluid in ventricles appeared normal. Section of the brain showed a large number of pin point bleeding vessels. This condition was not particularly marked about the mid brain.

Chest:- (1) Lungs - Appeared normal. Some altered fluid food in trachia and left bronchus.

(2) Heart - Transverse diameter increased. No pericardial fluid. Heart in diastole. Thickening of mitral and tricuspid cusps but aortic valve normal. No atheromatous changes.

Abdomen:-

(1) Stomach - Mucus membrane of cardia injected. Small intestine normal until about 2 feet from caecum. Here it became discoloured and injected but no ulcers seen. The colon was slightly thickened, discoloured and showed numerous shallow transverse ulcers, some of which were healed. Appearance typical of healing bacillary dysentery. Faeces fluid but normal.

(2) Liver - Normal in appearance.

(3) Spleen - Normal in size and appearance. Toxic type. Small accessory spleen.

(4) Kidneys - Large, good colour, normal.

(5) Bladder - Contracted. About one ounce of creamy pus. Bladder wall injected.

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(5) Bladder (cont)

Penis normal - no evidence of sores.

(6) Pancreas - Normal.

Cause of Death:-

Encephalitis lethargica.

Secondary Diseases:-

(1) Bacillary Dysentery

(2) Cystitis.

Surgeon Lieut.Comdr. R.N.

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No	226.	NAME OF DIAGNOSING DOCTOR				GUNN.	
NIT	8th Coast. R.A.	NATIONALITY	Australian	RANK AND NAME		GNR. WESTWOOD	
	① ENCEPHALITIS LETHARGICA ② Bacillary Dysentery.		DATE ADMITTED	19-6-42		Died 29.6.42.	

TREATMENT

Reported sick 7 days ago - passing mucus + blood. had fever. headache, vomiting latterly. pain continuously now. pain easier. still passing blood + mucus.

B.O. XV

Looks ill.

Generalised abd. tenderness. Tongue heavily furred, moist.

20/6.	B.O. 10. Muscle pain..	1. Mag Sulph ℥i Bi p.r. 8 doses.	S/B	Water only
21/6	B.O. 10. v. delirious. sweating freely. Prickly heat			
22/6.	No change in mental condition. - Prickly heat and over blisters + face.			
23/6	Delirious + vomiting. B.O. X.			
24/6	Vomiting stopped + b.o. less times. Feels better Behaves in odd manner, hard to arouse. very sleepy. + expressionless			
25/6	Complains of headache. T. 99 P. 106 R.N.D. Tongue clean. Savenry delirious + behaves in an irresponsible manner. Complains Gabd. pain. Abd N.A.D.			

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Westwood

DATE	TREATMENT	REMARKS
23/6	Is in semi-conscious condition. Aclon commands often some delay. No complaints. No rigidity. Pupils = . Tongue protruded normally - dil. fumed. left eyelid ptosed. Has sl. enlarged heart to left. ē blowing aortic systolic murmur. B.P. 135/80. - Pulse fuller rapid good V+T. Respirations increased. Abdomen. N.A.D. Some tonic rigidity of limbs. reflexes N.A. - Pain sensation hil.	
	Lumbar Puncture. C.S.F.. Clear. under lower pressure than normal. Globulin. : Cell count :	
24/6	Unconscious. urine + faeces. still sl. comatose. Pulse full. T. 100.2 P 110. Fundi : normal. sl. hazy. No papilloedema. Given 500 + 600 c.c. Glucose saline. ē some improvement.	
25/6	Quiet night. No incontinence. Appears sl. more conscious. Breathing appears adtomatic + deeper than normal, there is obvious urinifelous smell. reactions ++. Has edema of scrotum. hil else. Passed no urine till just before death. Albumen ++++.	
	1400. Patient died suddenly.	

昭和17年 6月 9日 14時30分 死亡ス。 陸軍軍醫中尉 齋藤修

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48100

NO.	246	NAME OF DIAGNOSING DOCTOR			Surg. Lieut Jackson. R.N.V.R.	Religion Pres.
UNIT	R.A.F.	NATIONALITY	British	RANK AND NAME	A.C.1. Toon	
DISEASE	Faucial Diphtheria	DATE ADMITTED	1.7.42	DATE DISCHARGED	Died. 4/7/42.	
DATE		INCIDENT				

Dysphonia too severe to take history properly.
Sore throat for 3 days.

C.O.A. Acute dysphagia, and dysphonia. Gross bilateral swelling of neck extending beyond jugular notch onto manubrium sterni.
Eyes Conjunctivitis ++. Tongue. Thick coat, moist foul. factor oro. characteristic.
Pharynx.

Whole area covered by membrane, Naso-pharynx occluded.
Extension onto anterior pillar and palate.
Soft brawny thickening of all tissues of neck.
Chest. Occasional râle over rt. apical zone anteriorly.
Heart following rest in bed, marked tachycardia & poor volume of pulse improved now regular 88/min
Abdomen Reflexes ++
Legs ✓.

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DATE	TREATMENT	REMARKS

2/11. 0130 Breathing more easily, some relief from hot poultices but the effort of taking them is affecting his cardiac rhythm.
Pulse at times, intermittently strong and fluttering
Dosing for short intervals - Coramine 1cc. given at 0135.

1030 Still distressed in respiration. Pharynx ISO.
Cardiac condition very much improved.
Urine:- Heavy cloud of albumen, passing small quantities only.

3/11. Another restful night, sleeping fitfully, dyspnoea still severe.
Pulse erratic Volume satisfactory.

2pm. Pulse weak. Camphor in oil. 1cc given.
Regurgitation of milk through nose, suggests palatal paralysis
7pm. 2100. Some improvement. dysphonia, not so obstructed.

4/11. 0130 Colour poor, pulse very poor intermittent and low volume.
High tracheotomy performed under local. Considerable relief obtained at once, but congestion persisted.
Caused bleeding from wound
1000 Not so good. Colour poor. respiration irregular with long periods of apnoea, pulse irregular

Rales except at ⟨ // ⟩ Congestion persists relieved with frequent cleaning of the airway and coughing up of membrane.

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DATE	TREATMENT	REMARKS
4/7/28.	1230 Respirations labored, left chest involved in broncho pneumonic process. On stimulation will cough up blood stained mucus and membrane with temporary relief. Lapsing into periods of unconsciousness. Cardiac stimulants required.	
	2.45 pm. Became acutely cyanosed, & muscle obstruction trachea and bronchi full of secretions, postural drainage helped but proved only very temporary relief. Both bronchi then aspirated through Jacques No 12 catheter. Colour improved but still ashen grey & cyanotic tinge. Extremities cold & cyanosed. Heart failing upon slightest exertion recovers with rest and Coramine	
	1700 Antitoxin-globulin 8000 units given (expired date 1940)	
	No improvement. following later Cardiac stimulants, respirations became sighing irregular & shallow - airway clear but process in lung too extensive Pulse at wrist impalpable. - Died at 2000	

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Case No. 443 Age 23 years

No.	174689		NAME OF DIAGNOSING DOCTOR		Asstt: Surgeon P.S. Sangha I.M.D.
UNIT	H.K.M.C.	NATIONALITY	Indian	RANK NAME	Driver Shaffi Mohd
NATURE OF DISEASE	Acute Gastro-Enteritis	DATE ADMITTED	30.6.42	DATE DISCHARGED	Died 6.7.42. at 5.45. p.m.

DATE	TREATMENT	REMARKS
30.6.42	Rice Water AD. Lib.	
	Condition bad on admission	
	Mist Saline oz Stat.	
	Mist Saline oz 2 hrly.	
1.7.42.	Morphia gr 1/6 s.c.	
	Tab. Dagenin 4	
	Morphia gr 1/6 s.c.	
2.7.42	Tab. Dagenin 2. B.D.	
	Resin water AD. Lib.	
	Condition toxic & bad	
5.7.42	Enema sapo 0 Ü	
	Normal Saline 0 ii s.c.	
	Condition toxic & worse	
6.7.42	Liquids by mouth A.D. Lib.	
	Patient expired at 5.45. p.m.	Died at 5.45.p.m. 6.7.42.

(Signed) P.S. Sangha
Asst. Surgeon I.M.D.
L.W. Ashton-Rose
Major IMS.
Comdg. 3rd P.W. Hospital.

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入院番號 No.	248	診斷軍區名 NAME OF DIAGNOSING DOCTOR		C. Jackson	
部隊 UNIT.	Royal C. of Sigs.	國籍 NATIONALITY	British	階級兵名 RANK & NAME	L/C.James Jack
病名 DISEASE	Clinical Diphtheria	入院日 DATE ADMITTED	3/7/42	退院日 DATE DISCHARGED	Died 6/7/42

日 DATE	治 方 TREATMENT	摘要 REMARK
3/7/42	H.P.C. Sudden Onset. 3 days ago. Headache, pain in limbs. anorexia fever Then developed dysphagia ' phonia 1 day ago Swelling of neck.	Fluids Ad lib Rinse flat S/B
C.D.E.	Apathetick swollen, neck moderate dysphagia, Mild conjunctivitis, dyspnaea. Foul foetor oris. Fauces membrance that bleeds on separation Septic scabies of hands and legs. Chest Heart. N.A.D. Br.Br. 7 creps. rales Urine. Albumen heavy cloud. Smear: from membrane on left tonsil - shows mixed flora & no. predominent organism, from blister on left hand: - many polyimorphus and diphtheria organism.	
4/7/42	Alittle more comfortable, physical signs in chest about the same, slight increase in membrane, breathing easily but dysphagia worse. Sleeping well.	
5/7/42	Considerable extension ofmembrane onto post pillar and uvula Dysphagia ++ 4.45 p.m. Respirations becoming more difficult. Lies in apathetic state on right side appears most comfortable position. Barely and coshil movements, abdominal breathing almost entirely. (? Intercostal parsisis) Colour, deeply cyanotic (very like an influenzal pneumonia). Pulse rate very rapid, but regular, failing at intervals.	

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DATE	TREATMENT	REMARK
	Both lung fields, congested, R.> L. There appear to be a fairly good pharyngeal airway.	
5.30 p.m.	General deterioration in condition. Seen together with W.L.Gunn - Considered, in view of extensive envolvement of lungs that faucial obstruction is not the cause of cyanosis.	
8.30 P.m.	Some improvement both in colour and respirations. Both bases have no A.E. bubbling rales over apical zones. Tachycardiac c poor volume. Local condition in fauces, suggest membrane is separating . Condition gradually deteriorated and "chest filled c fluid"	
6/7/42	Died at ~~9.40.~~ 1.40 AM	

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CASE No. 331

No.	9893		NAME OF DIAGNOSING DOCTOR		Captain B.I.Evans I.M.S. Captain T.P.Sundram I.M.S.
UNIT	5/7th R.Regt.	NATIONALITY	Indian	RANK NAME	Sepoy Ranga Khan
NATURE OF DISEASE	Anaemia Secondary Broncho-pneumonia	DATE ADMITTED	30.5.42	DATE DISCHARGED	Died at 1.45 P.M. on 8.7.42.

DATE	TREATMENT	REMARKS
30.5.42	Patient complains of giddiness, progressive weakness and Constipative. Anaemia Marked + + + (No. 9 two lots (Mist. Saline oz Haemic + (early next morning	Date 17.10.42 Weight 115 lbs.
31.5.42	Mist A.Pc. oz stat.	
3.6.42	Mist Ferri et Quinine citras oz Tds.	
6.6.42	Mist Saline oz Tds. (One day)	
10.6.42	Mist Quinine oz Tds.	
18.6.42	Temp. 104.F. Rhonchi in chest all over with petches of consolidation. Stop Quinine 6.30 P.M. (M.B. 693 soluble one ampule 1 M. (Mist APc. oz Stat.	Condition Serious
19.6.42	Two tabs every 4 hours Sulphonamide = total 12	
20.6.42	" = 12	22/6/42 Milk 1 bottle
24.6.42	Mist expectorant stim oz Tds.	
26.6.42 27.6.42 30.6.42	Tabs Trianon 6 Tds - Total = 18) " " 3 Four times a day=12) " " to " " " =12)	Tabs 66
1.7.42	Mist. expect stim oz Tds. Condition serious with signs of heart failure.	
8.7.42	Condition dangerous. Caramine one ampule 8c at 1.30 p.m. Died at 1.45 P.M. on 8.7.42.	

(Signed) C.P. Sundram
Captain I.M.S.

L.W. Ashton-Rose
Major

3rd Prisoners of War Hospital

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